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The Nursing Care in Thoracoplastic Operations

JULIA IRENE KEMP, R.N.

ABOUT a century ago, it was realized that in unilateral pulmonary tuberculosis, when the lung collapsed spontaneously from pneumothorax, healing of the tuberculous lesion sometimes directly resulted. This principle (Fig. 1), *i. e*, the collapse treatment of the lung in tuberculosis, was applied artificially with success for the first time in December, 1907, by Friedrich, Professor of Surgery at the University of Marburg, working with Brauer, Professor of Medicine at the same university. Lung collapse was obtained by removing the entire length of every rib on one side and allowing the chest wall, thus rendered pliable, to sink in. The operation was performed in one sitting. This patient survived and fourteen months later his tuberculosis was greatly improved. However, this procedure proved highly dangerous; Friedrich reported twenty-seven cases in 1911, with ten deaths.

Not only was the surgical shock great, but the operated side of the chest, deprived of its bony framework, swung in and out freely with respiratory movements, producing the so-called paradoxical respiration and "mediastinal flutter." Dyspnœa resulted, often with acute asphyxia, or later aspiration pneumonia developed in the opposite lung. The operation was successful in putting the diseased lung at rest, but the breathing mechanism was too seriously upset and shock too great to permit its further employment.

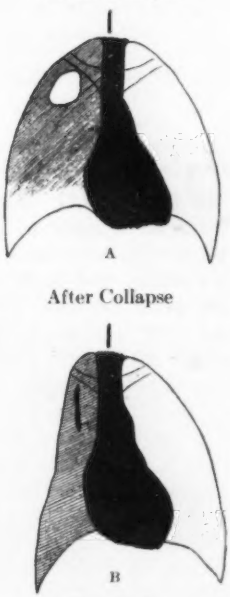

FIGURE 1

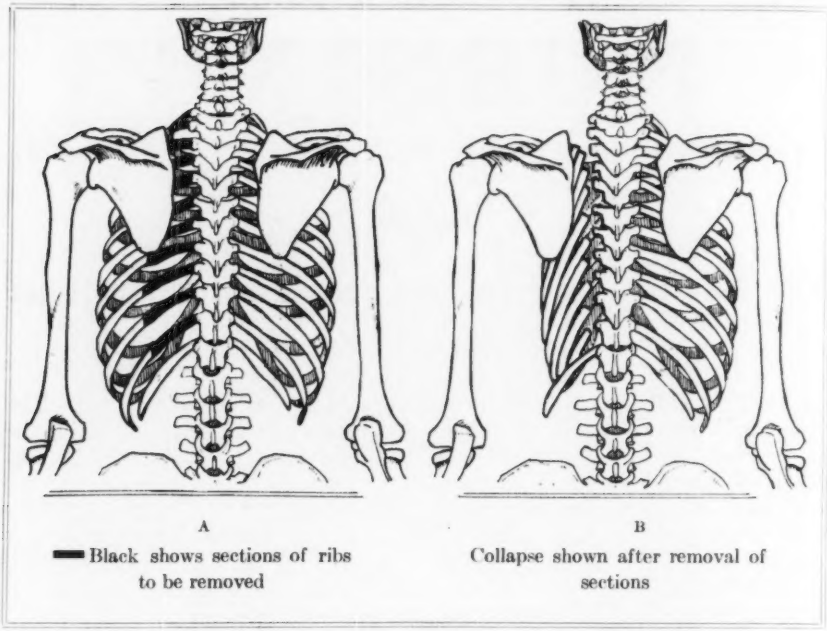

FIGURE 2

Sauerbruch's Operation

FERDINAND SAUERBRUCH, Professor of Surgery at the University of Berlin, was an interne in Friedrich's clinic, and witnessed this work. He later modified the operation so as to free it of those objections and through his efforts chiefly, the operation, called paravertebral extrapleural thoracoplasty, has become accepted as standard and the indications for its use established in detail. By his suggestion, the chest wall is made to fall in and at the same time retain its stiffness. Each rib is disconnected from its support, the spine, by removing a short piece of it in the back (Fig. 2, A). Without their natural support, the ribs fall down and in, just as the branches of one side of a tree would behave if they were cut through except for the bark where they spring from the trunk (Fig. 2, B).

Today this operation is done under local or general anæsthesia; in one, two or three stages. The patient is placed usually in a semi-recumbent position on the operating table (Fig. 3). A long incision is made parallel with the spine on one side and deepened so as to expose the ribs near their vertebral attachments (Fig. 4). The

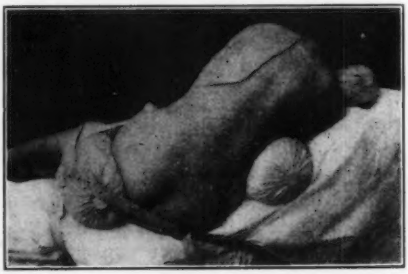

FIGURE 3

periosteum of each rib is scraped off and a segment of rib four to five inches in length removed, until as many as desired for that sitting have been taken out. The wound is then sutured together, providing a rubber drain to remove the bloody fluid that oozes from the tissues afterwards. Dressings and a firm binder are then applied giving the chest support and compression. From two to three weeks are allowed to elapse between each two stages and the entire procedure must be accomplished within one month in order to assure thorough collapse, since bony regeneration occurs after that and holds the chest wall out. When collapse is complete (Fig. 5) a brace is worn for two or three months (Fig. 6). As soon as the patient can be moved, he should be taken to a sanatorium for careful supportive treatment and upbuilding, since it requires months to accomplish permanent cure of the lesion.

Indications for Operation

THORACOPLASTY is indicated in certain types of cases, and its success depends directly upon experience in selection. The disease must be limited to one side, and it must be ascertained, especially by spirometer tests, whether the "good" lung is able to carry the whole respiratory function, before collapsing the diseased lung. In tuberculosis, it is used only where the disease is chronic and is fibrous in type, rather than caseous, and where pneumothorax cannot be done or has not been effective. It is also indicated in bronchiectasis, which is a chronic suppurative condition of the lung in which the bronchi are dilated and the patient raises quantities of sputum; also in chronic empyema.

FIGURE 4

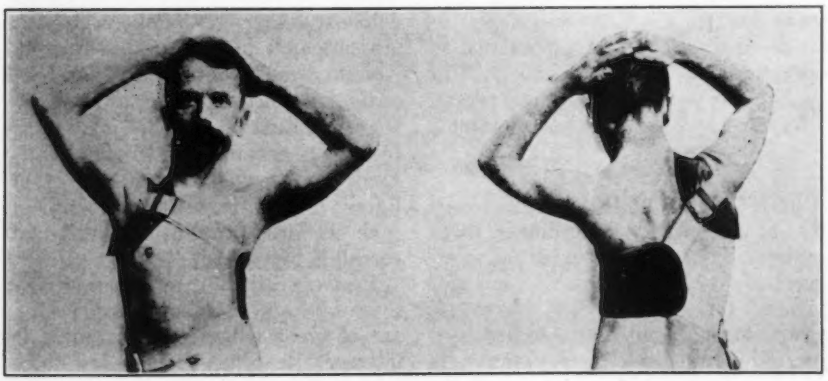

FIGURE 5

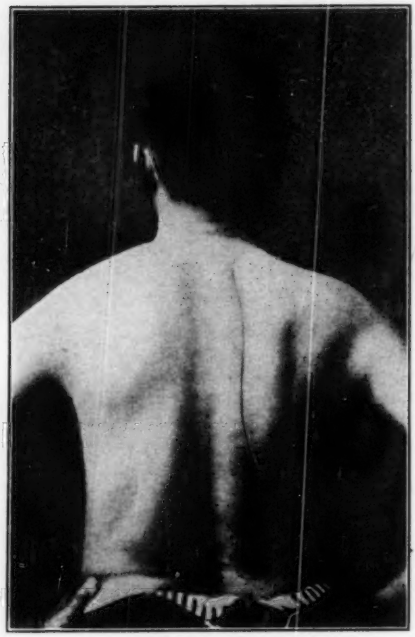

FIGURE 6

Results

THE best results in tuberculosis have been attained by Professor Sauerbruch. His figures show a mortality of four per cent, cure in sixty per cent, and marked benefit in twenty per cent. This success has been due to his large experience in selecting the right type of patient for operation; dexterity and judgment in performing the operation; and proper after-care and sanatorium treatment.

Nursing

PRE-OPERATIVE. As in all cases of long, devastating illness, these patients require the very best of nursing. Most of them have been in sanatoriums for several years, have had adequate food, and complete bed rest. Nourishment in attractive forms is offered at frequent intervals during the day, and at night whenever the patient is wakeful. The diet is high in calories and readily digestible. Between the three regular meals, the feedings may be of fruit juices, albuminous drinks, eggnogs, custards, junkets, and the like. The sputum is collected in sanitary paper cups and measured each day for some time prior to operation for comparison with the post-operative production. The quantity of sputum is a valuable indicator of the benefit of the operation.

The psychology of the patient is here to be carefully considered. During his prolonged sanatorium period he has usually become intimately acquainted with things medical and is quick to recognize evidence of changes for better or worse. Unusual care has to be practiced in keeping depressing facts from him and sustaining his morale. These patients are often hypercritical and recognize incompetency and lack of experience with tuberculosis in those that care for them. Tact, firmness, and character in the staff are required, often to a marked degree.

Preparation for Operation. The axilla on the affected side is shaved, and the surgical field, extending from the base of the neck to the crest of the ilium, from axilla to axilla, and the whole shoulder on the operative side, are prepared in the routine manner. About twenty minutes before the patient is called to the operating room, the usual dose of morphia is administered. If general anæsthesia is to be used, no breakfast or liquid is allowed; if local, then a light breakfast, such as toast and coffee, milk and cereal, is permitted.

Post-operative. Shock is to be looked for and blood pressure readings are of great value in determining its degree. Readings must be taken frequently. The patient may return

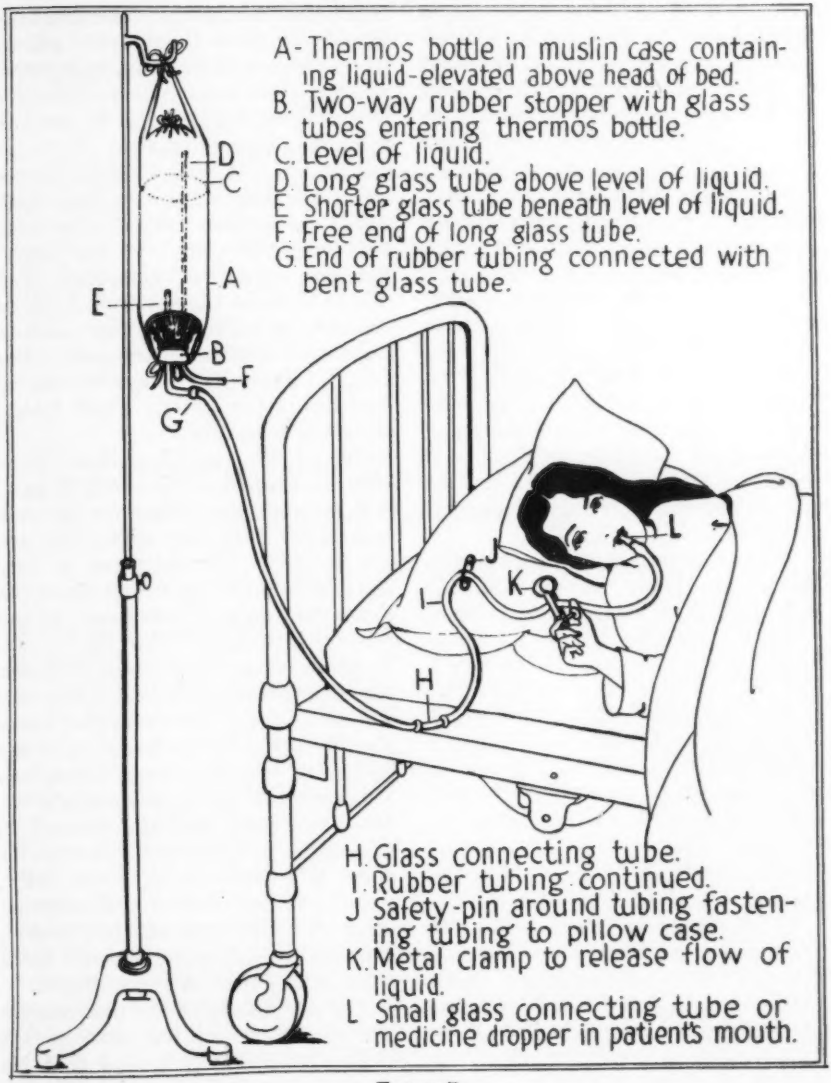

FIGURE 7

from the operation already shocked or pass gradually into it. A crisis often occurs the afternoon of the second day, due to what is believed to be autotuberculinization. Symptoms to be looked for are cyanosis, gasping respirations, rapid, thready pulse and a cold and clammy skin. The position should be flat, on the back or the "good" side. Transfusion or infusion of saline is often required; warmth and stimulants are applied.

Whether shock develops or not, a nurse should be in constant attendance. The operated side of the chest must be supported when the patient coughs. He may be instructed to indicate that he must cough by raising a finger. If the side, deprived of its bony framework is not supported, coughing causes more pain and may even result in hemorrhage or rupture of the lung and death. Support is obtained by placing the hand gently and firmly against the collapsed side. From the time of return to the ward and for several days morphine is required regularly and in large doses to rest the patient, control coughing and aid respiration. Later codeine is sufficient for this purpose. The sputum is measured and recorded each twenty-four hours.

There is usually a very copious discharge of bloody serum from the wound which may necessitate a change of dressing within the first twenty-four hours. It is inadvisable to disturb the patient at this time more than absolutely necessary. Experience is required in distinguishing between this discharge and post-operative hemorrhage. So much tissue is dissected at the time of operation that the whole wound weeps bloody serum much more freely than would be expected in an abdominal wound.

Fluids should be forced, and given by mouth immediately after operation if the patient is not vomiting. As an aid in nursing and because one arm of the patient is incapacitated, we have devised a means by which the patient may help himself to water as soon as he is able (Fig. 7). A thermos bottle is elevated from a standard at the head of the bed. The bottle is inverted and through its cork pass two glass tubes, one barely entering the bottle and the other reaching to its bottom. Long, new rubber tubing is attached to the first tube and held by a safety pin to the patient's pillow. At the center of the tubing is interposed a glass connection as indicator of passage of fluid, and at its end is a medicine dropper tip to serve as mouthpiece. A spring clamp is provided on the rubber tubing, with which the patient controls the fluid. Iced water is placed in the bottle. Patients sometimes complain of a rubber taste in the water and this is obviated by adding flavoring, such as a little unsweetened fruit juice. Orange or grape juice may, indeed, be substituted for water. Fluid intake should be measured.

One of the most important items after the acute operative stage is past, is to build up the patient for the next operation. But here difficulties are encountered. Surprising as it may seem in a chest operation, these patients are frequently distressed by gas in the intestines. The theory accepted by chest surgeons as a reason for this phenomenon is a reflex disturbance of the nerves of the intestines produced by the irritation of the intercostal nerves during operation. Frequent tap-water or soapsuds enemata relieve the condition somewhat; mineral oil in thirty cubic centimeter doses is given once or twice daily; and appetizing food of a non-irritating, high caloric type with low residue, is given in small quantities, six times daily, rather than the usual three.

The psychology of the post-operative patient is much the same as that of the pre-operative except that his apprehension regarding his operation is over. Now he fears that all his discomfort and pain will not have produced the desired results—the cure of his tuberculosis. Moreover, he faces several months of strict régime in a sanatorium. The nurse can do much to enliven his spirits. Visitors are

discouraged, first, because the patient is easily fatigued; second, because infections may be carried to him.

Summary

AN account is given of the development and technic of extrapleural paravertebral thoracoplasty. The principle of operation, method, indications and results are explained, and the nursing care discussed in detail.

In nursing care are emphasized the following points:

Sputum should be collected regularly before and after operation as a valuable index of the benefit derived.

Diet should be high in calories, appetizing, and easily digestible.

The psychology of the patient should receive particular consideration.

Post-operative shock is frequently seen.

A special nurse is necessary to give support to the collapsed side in coughing.

Experience is required to distinguish between bloody discharge from the wound and post-operative hemorrhage.

As an aid in forcing fluids, a new apparatus is described in detail.

References

A DETAILED treatise, with complete bibliography, may be found in John Alexander, "The Surgery of Pulmonary Tuberculosis," Lea and Febiger, 1925.

Effect of the Grading Committee Report on Schools of Nursing[1]

CARRIE M. HALL, R.N.

I DOUBT very much if the first report from the Committee on the Grading of Nursing Schools has yet had any tangible effect upon the nursing schools of the country. Perhaps this is a pretty broad statement to make without having previously secured first-hand information on this point from a large number of schools. To have secured this information would have necessitated the sending of a questionnaire. I am sure that those of you who are in charge of schools will be glad that I have refrained from burdening you with one on this point. I have, however, talked with many heads of schools from different parts of the country, with many other nurses, and others, and I am convinced that my original statement is true. I am sure also that many persons are thinking and talking about the report and many waves have been set in motion, whose widening circles will ultimately produce action. At present, however, one can do little more than predict results and I make not the slightest claim to being a prophet.

I shall not attempt in any sense to review "Nurses, Patients and Pocketbooks." To do so would be to deviate from the assigned topic. It would be impossible to do it adequately in one short paper. Others have tried and some have shown a shocking ignorance of the contents and its author—I refer especially to the book review published in the October 6 number of the *Journal of the American Medical Association*.

The report was issued in June. It has had fairly wide distribution and reading. Some of the material had been presented at state and national meetings and published in nursing and other journals previous to its

[1] Read at the annual meeting of the New York State Nurses' Association, Brooklyn, October 23, 1928.

publication in book form. We were prepared, therefore, in a measure, for some of the facts. The report frankly states that the conclusions reached had already been suggested years earlier and are to be found in nursing literature—that it supplements the opinions of thoughtful individuals by a firmer foundation of testimony from large numbers.

The summary presented at the Louisville Convention and now published in reprint form is doubtless the most concise and accurate review which we may hope to have. It points out the rapid growth of schools, the surplus of graduates, the lack of employment, low educational requirements for entrance, the disrepute brought by the under-educated group to the profession as a whole, the need for quality in nursing service rather than quantity.

You will say there is nothing new in these suggestions, and I shall agree—and the author so states. But the emphasis put upon the need for swift action was breath-taking. At the conclusion of that Louisville address, I experienced a feeling of such utter helplessness as I have felt but once before. That other time was in 1917, when in convention in Philadelphia, I received a summons to return to Boston, to mobilize my unit and proceed overseas. I am not sure but that it was easier to face that summons and the uncertainties involved, than to accept the challenge of the Grading Committee, which was, in effect, "We have furnished the facts—what is the nursing profession going to do with them?"

Four tasks are implied:

1. To reduce and improve the supply of nurses.
2. To replace students with graduates.
3. To help hospitals meet costs of graduate service.
4. To get public support for nursing education.

To reduce and improve the supply both in large schools and in small, and to do it at once, is the thing which makes us stagger. It is impossible to make a complete right-about-face and approach the nursing-school question from a new angle. Hospital and nursing problems for as many years have been too closely inter-related. We have striven so long to fill our schools on the basis of the hospital's needs. Our buildings have been built for student-nurse service. We must now tell the hospital authorities that the hospital patients must be nursed in some other way, if we are to follow the implications of the report. The question of student enrollment must now be met on the basis of the numbers which may be absorbed into society, and find employment and economic support. It is impossible to command resources at once which make it possible to limit enrollment to the degree indicated in the report. Trustees are not an easy group to convert. It is easier to reach the nursing groups. The question is vital to them. It has not yet become so vital to the other groups. Occasionally one succeeds in getting a trustee to read the book or at least scan the summaries. One trustee, after a fair reading of the book, said, "Of course *we* do not need to reduce *our* school because *we* are producing quality now—and of course the small hospitals cannot afford to reduce their schools." This is, I believe, a pretty common trustee reaction. It does not promise well for providing funds for employment of more graduate nurses and a limitation of student enrollment. The average trustee still considers nursing (either graduate or student) a mere by-product of the hospital's activities. Boards of trustees which often have difficulty in securing a quorum for the transaction of business, and whose members

give time only for what they consider the essentials, would not welcome the presence of the superintendent of nurses at their meetings and, what is more, probably would not tolerate it. The implications in the report are so very like recommendations, that trustees and many hospital administrators imagine that the Committee has power to condemn and to close schools which do not meet the standards which the Grading Committee may set up.

A layman hospital superintendent of a small hospital recently said to me, "I am very apprehensive concerning the results to our school when actual grading occurs." He was not apprehensive enough, however, to support the superintendent of nurses in an improved teaching program.

Hospital Management of October 15 has published a symposium on the question, "Will the Grading Committee Close All the Small Schools of Nursing?" The question in itself shows how little the function of the Grading Committee is understood. The answers are in response to the question, "Should a denominational hospital of fifty beds in a city contain a school of nursing, in view of the recommendations of the Grading Committee?" The replies are varied, pertinent, wide of mark in some instances, and illuminating. Mr. Watson of Kahler Corporation, Rochester, Minnesota, says:

Since reading the report of the Committee on Grading of Nursing Schools, I am convinced that this will mean the elimination of some of the existing schools. I am inclined to believe that it will mean the "survival of the fittest," based on clinical material and teaching facilities. Certainly, we cannot go on turning out nurses in the quantity that we have been when the demand is less than the supply. I am of the opinion that standards will be increased, particularly entrance requirements, and that a great many of the endowed hospitals will go on a graduate basis. We are in the midst of a transition, and I would hesitate to recommend the establishment of any new schools under conditions obtaining at the present time.

Dr. Walter E. List, Minneapolis General Hospital, says:

In view of all discussion that is now going on, one must believe that a new hospital of fifty beds should not establish a nursing school. It is my opinion that the Committee on Grading of Nursing Schools will do a big piece of work, and I am sure that with their investigation, research and study will come conclusions that will represent the best thought as of today in nursing schools.

Frank E. Chapman, Mt. Sinai Hospital, Cleveland, says:

It would seem to me that those responsible for the development of the hospital mentioned should ask themselves whether or not they are going to have an educational point of view towards their student nurses, or whether they are merely operating a school for the purpose of manning their wards. They should ask whether or not they are going to be able to furnish the clinical facilities and the educational personnel necessary. If they can answer the latter question in the affirmative, and can assure themselves that they have the proper attitude towards the nurse in training, then I think, by all means, they should conduct a school.

I cannot speak for the Committee, but I think there is nothing further from their thought than the elimination of a properly functioning school. They do, however, object to a school, whether it is large or small, that exploits a young woman.

Observation over a long period of years has convinced me that the best nurse is not necessarily developed in the large hospital; that there are several phases of small hospital training that produce a more sympathetic, better all-round qualified nurse than the larger hospital.

What little knowledge I have of the Committee on the Grading of Nursing Schools' work leads me to state very emphatically that they are not going to establish standards that cannot be accepted by all schools of nursing that are conscientiously trying to render the right type of educational service to the student nurse. There is no question that they will attempt to establish standards far above a great many schools of nursing today, but anyone with any knowledge of the situation

at all realizes that many hospitals are operating schools of nursing which have no moral right to do so.

There are other answers which are not so *broad-minded*, shall I say, and the influence of nurses in the responses is gently discredited. The quotations which I have selected are not the ones emphasized in the columns of *Hospital Management*. These sympathetic viewpoints from the minds and pens of some hospital administrators are encouraging. We secure crumbs of comfort from them and from other sources such as the topics recently presented at the Nursing Section of the American Hospital Association in San Francisco. They were:

1. "Does the School of Nursing Need Freedom from Hospital Control in the Interest of Nursing Education?"
2. "How Would the Hospital Be Affected by Nursing School Autonomy?" and
3. "The Separate School and Its Budget."

Five years ago it would have been impossible to have presented these subjects on a program of that organization. If the findings of the Committee are to be accepted, and they are so in accord with the doctrines of many of us that I think they must be accepted for the most part, I suspect that we need to do a good deal of educational work within our own group. I am one of those persons whose interest in "statistical methodology is mild," but when told that by 1965 our number of graduates annually will be more than trebled and the numbers out of all proportion to the general population, I can believe it, with only a few mental reservations, and become quite shocked.

But what can I as an individual do about it? To check such growth surely requires concerted action. The head of a Sisters' hospital, after listening to some of the salient features of the report, said, "We must put the entrance requirements right up to full high school and nineteen years of age." But the report tells us that raising standards will stimulate, rather than limit enrollment. May we not, however, expect raised standards to improve the quality of the product even though they do not limit it? Many schools now require full high school preparation. Some have named a definite per cent—as a minimum of 70 per cent. May not such schools now go one better and require a minimum of 75 or 80 per cent? We know that high school education or even college education is not a guarantee of fitness, but at least it is something which can be measured and recorded as a basis for selection.

Dr. Burgess showed some illuminating charts at the Hospital Standardization Conference of the American College of Surgeons. The particular point which she made was that education is a relative thing, that thirty or more years ago the proportion of nurses having high school preparation was thirty points higher than high school education of women in the general population—that in a few years, at our present rate, the percentage of nurses with high school preparation will be lower than that of the percentage of women in the general population.

On the same platform, in the afternoon of the same day, Dr. Rappleye, in discussing medical education, said: "Graduation from college is rapidly becoming the general standard of education."

I am sure that few of our doctor friends would admit that this could reach to the group of nurses, but we may make our own applications, and we can quietly and steadily and without increased funds raise our entrance requirements. We need a good deal

of self-examination. We need to raise such questions as:

1. Does my teaching field offer sufficient teaching and clinical experience to prepare women for nursing?
2. Are funds available to provide adequate teaching and supervision for the body of student nurses?
3. Is the load of nursing service carried by students or—
4. Is the bulk of the nursing carried by a body of graduates supplemented by student service?
5. What are the educational standards for admission?
6. How are undesirables eliminated?
7. Must they be retained for the safeguarding of the nursing in the hospital?
8. May they be eliminated to safeguard the care of the sick in the community?

I suspect that grading will comprise some such questions rather than the much feared A B C forms.

I think there is a good deal of danger in broadcasting too extensively the facts about the surplus of nurses. I do not mean that I approve of admitting women to the profession for whom there will be no work, but news travels very rapidly by word of mouth, and it is quite understandable that if a great deal of publicity is given to the dangers of over-production, we may frighten off some of those very desirable women whom we wish to attract.

Already the results of unemployment in the private duty group are being felt in the institutions. It is much easier to fill graduate positions with desirable candidates that it was a few years ago, and the turnover is less. Experience is a great teacher, and the nurses are quick to recognize the safety of the permanent position over the uncertainty of private duty or hospital specialling. The facts about unemployment pass on quickly to their sisters and cousins and friends who are potential candidates. While the economic influence may not be the ideal regulator for an idealistic profession, it probably is a sure one.

Schools are going on filling their classes and having no difficulty in doing so. I dare to hazard the opinion that the entering classes this autumn were the largest ever enrolled in the history of our schools. When heads of schools get together, it is still a matter of congratulation that there are plenty of applicants of high school grade. Even many of the poorer schools are pleased with the number and the preparation of their candidates. And why should they not be pleased and gratified? There are the patients in the hospital's beds to be cared for. Here is the system, firmly entrenched, and who is to overturn it? Surely not the harassed superintendent of nurses.

It is about as easy to put into practice the implications of the report as it is to enforce prohibition. If every one believed in prohibition, it would be easy to enforce it. People must first be made to want it, and so with the implied changes in nursing education, people must first be made to want them. The nursing profession alone cannot bring about a reform. Hospital administrators, trustees, the public, all are involved. We alone can do nothing radical. We must be sure of what we want and carry the other groups with us, I suppose, through that slow process of education.

Let us use caution and discretion. When 50 per cent of the medical schools were closed over a period of several years, about twenty years ago, the rural communities lost a medical service which has never been replaced and from which they have suffered ever since. Let us profit by that example.

In our reforms let us not deviate too far from the *art* of nursing. Let us not "sell our goods," "provide nursing in small packages," nor "find

out what the people wish to buy." Of necessity nursing service must be paid for if nurses are to maintain economic integrity, but the right-minded nurse will expect to give more in service than can be paid for in currency. It scarcely seems merely a question of how much service, measured by time, the patient may wish to buy, but rather through the exigencies of the situation how much he may be obliged to have. Not more than four hours of actual care may be essential, but since nursing care means quiet, rest in bed, cleanliness, preparation of food, ventilation, etc., the four hours of actual care must be spread over twenty-four hours. It is not always possible to concentrate it in one block of time, or even two. The personality of the patient, his idiosyncrasies, ability to stand pain, and other things must enter into the nursing problem.

May it not be that the employers of nurses need also to give consideration to costs of illness and nursing? If buying commodities in small packages is the modern way of living, it seems equally true that the modern method of family financing is by budgeting expenses. If families would budget for probable illnesses they would then be prepared to meet costs, rather than to face emergencies. Doubtless hourly nursing in homes and group nursing in hospitals will in a measure help in the distribution of nursing service and in the reduction of costs, but I feel it is not the solution to the whole problem.

Let us face these problems squarely, but let us also continue to cherish our idealism, and let us never forget that although the basis of good nursing must rest solidly on education and on science, the practice of it is an art which cannot be measured in statistical studies, which cannot be taught in didactic fashion, but which must emanate from that desire to help—a service which in its truest sense can never be bought.

Correspondence Schools

DID you have any notion that seventy million dollars are paid out every year by American citizens to get a chance to learn something from printed lessons through the mails? Do you, now that you know that, realize what seventy million dollars means, in comparison with the money spent on our public school training? It is as much as the combined school budget of fourteen of our states. We would have a thing or two to say, wouldn't we, if every penny of that school money were not scrupulously accounted for? What if promoters were making, not only good yearly livings, but 15 per cent, 25 per cent, 50 per cent, out of the money set aside to teach our children? Why should they be allowed to make that out of money spent to teach our grown-ups?

Seventy million dollars income a year, paid out of the pockets of wage-earning Americans who would like to learn something! Who gets it? During the year 1923, one of the larger correspondence schools signed a sworn statement that three-quarters of one cent, out of every dollar they took in, went to pay for the instruction given. The rest went to high-priced salesmen and to the promoters. You are not surprised that a goodly number of new millionaires have sprung up during the short time since the paying correspondence school was invented. . . . Until very recently nothing has been recognized in that code which would prevent any man from advertising that his course of lessons will teach anybody (no mention made of previous training or natural ability) a technical vocation like mechanical engineering "in a few pleasant lessons that will in no way detract from your present mode of life." The unspoken feeling has been that if anybody is imbecile enough to believe that he can learn mechanical engineering, or oratory, or "culture," or how to play the violin in a few pleasant lessons without interfering with evenings at the movies and attendance on dances—why, that's his hard luck. Anybody so thoroughly an idiot is fair game for whoever can empty his pockets.—From "Why Stop Learning?" by Dorothy Canfield Fisher.

NOTE.—The address of the newly formed National Home Study Council, where reliable definite information in detail can be secured about correspondence schools is, 839 Seventeenth Street, N.W., Washington, D. C.

The Canadian Nurses' Association

JEAN WILSON, REG. N.

THE Canadian Nurses' Association was founded in October, 1908, at the time of the first annual meeting of the Canadian Society of Superintendents of Training Schools for Nurses. Representatives from sixteen nurses' organizations in the Dominion of Canada attended.

The present membership consists of nine provincial associations of registered nurses, eleven local graduate

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nurses' associations, and twenty-nine alumnae.

Within the C. N. A. there are three national sections: the Public Health Nursing Section, created in 1920; the Private Duty Nursing Section, formed in 1921; and the Nursing Education Section, formerly the Canadian Association of Nursing Education, originally called the Canadian Society of Superintendents of Training Schools for Nurses, and affiliated with the C. N. A. from 1908. The Nursing Education Section was formed in 1924.

General meetings of the organization are held biennially. In the interval the business of the Association is carried on through the Executive Committee. This committee consists of a president, first and second vice presidents, an honorary secretary, an honorary treasurer, the chairmen of the three national sections, and four councillors from each provincial association; these councillors are the president and the chairmen of the three provincial sections. In this way there is equal representation of provincial associations of nurses in the national body.

Each provincial organization has obtained an Act for the Registration of Nurses. Thus each province has complete autonomy in regard to legislation for nurses. The national organization is the instrument by which mutual understanding and unity among organizations of nurses in Canada are promoted. Other purposes for which the C. N. A. exists are: to acquire a knowledge of the methods of nursing in every country; to elevate the standard of professional nursing education; to promote a high standard of professional honor among

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nurses in all their relations; to encourage a spirit of sympathy with nurses of other countries, and to afford facilities for international hospitality.

In 1916 the Association purchased the *Canadian Nurse*, and since then has owned and edited this journal as the official organ of the Association.

In 1918 the founder of the Association, Mary Agnes Snively, was asked to act as archivist. To this request Miss Snively graciously acceded, and at the general meeting in 1921 she presented a comprehensive and interesting report of the organization and its activities during the years 1908 to 1912. Later there was added to this report a brief historical sketch of the Association until the year 1924, and the entire material was published in booklet form in 1926.

From the beginning it was recognized that the Association should have a central office, but it was not until 1923 that a national office was established in Winnipeg, Manitoba, and an executive secretary appointed.

EDITH B. HURLEY, REG. N.
Honorary Secretary, Canadian Nurses' Association

MABEL K. HOLT, REG. N.
National Chairman, Nursing Education Section, Canadian Nurses' Association

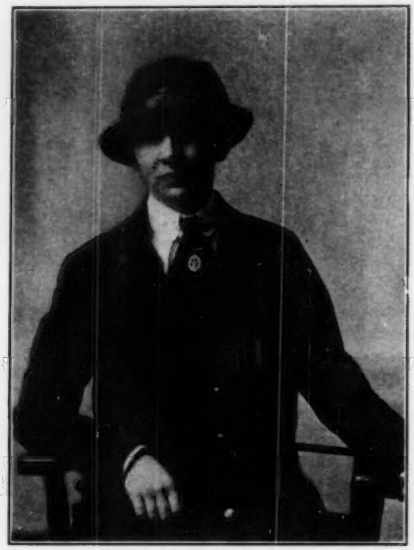
The following year the office of the *Canadian Nurse* was moved to the national office.

In countries of vast territory, such as Canada, with its small and scattered population, one might expect to find it difficult to maintain a national spirit among the members of any national body. However, the national solidarity of the Canadian Nurses' Association was well demonstrated when its members undertook the raising of funds for a memorial to their sisters whose lives were given on active service during the Great War. In 1926 there was unveiled in the Hall of Fame, Federal Buildings, Ottawa, a most beautiful memorial, presented by the Association to the people of Canada, in honored memory of Canadian nurses.[1]

Among present activities of the

[1] A description of the ceremony and a picture of this memorial appeared in the *American Journal of Nursing*, November, 1926, page 838.

Association are: the question of change in membership in order that dual affiliation may be eliminated; the national enrolment of members of the C. N. A. for emergency service in war, disaster, epidemics, etc. This enrolment is being effected through coöperation with the Canadian Red Cross Society and with consultation



ELIZABETH L. SMELLIE, REG. N.
National Chairman, Public Health Section, Canadian Nurses' Association

with the Federal Department of National Defense. Another activity is the raising of funds to aid in the study of nursing in Canada under the direction of a Joint Committee of the Canadian Medical Association, the Canadian Nurses' Association, and the Hospitals' Associations.

The National sections have numerous special committees active with

AGNES JAMIESON, REG. N.
National Chairman, Private Duty Section, Canadian Nurses' Association

matters relating to their respective interests.

The Association is affiliated with the Canadian Council on Child Welfare, the National Council of Women of Canada, and the International Council of Nurses. Affiliation with the International Council took place in 1909, and now, when the C. N. A. has reached its majority, its members are busy with arrangements in preparation for the Sixth Congress of the Council, than which no more fitting celebration could be observed by Canadian nurses. It is with hearts full of joy in anticipation of meeting and conferring with their sister members in the International Council that they are preparing for the Congress. A hearty and sincere welcome awaits each guest.

The Library in a Mental Hospital

MARY R. MORRISSEY

THE question of whether a library is of value in a hospital or not is no longer a debatable one. Every hospital maintaining a library, or having some kind of library service, quite freely admits that such an activity is not only a benefit to the patients, but to all connected with the institution. The American public has become a reading people, and the invalids need books just as much, if not more, than the well members of society. In the present age, books have become a necessity in the lives of almost every one.

In hospitals caring for nervous and mental patients, well-established libraries have proved themselves to be valuable therapeutic agents. The idea behind all activities carried on in a mental hospital is to keep the patients occupied and give them normal, healthful recreation. The modern hospital aims to give its patients as normal a day by day existence as possible, and in such a scheme the library has a very definite place. The reading of books is a universal occupation or pastime and, for people confined in a restricted environment for long periods of time, a real necessity. There are many hours during the day when books fill in the gaps which otherwise would be long and deadly.

A hospital with an average of one hundred and seventy-five patients per day ought to have a resident librarian. It takes the full time of one person to keep the collection alive, select new books, and make the contacts necessary in order to interest the patients in reading. The librarian must know, and be known to all the patients in the hospital. Daily visits should be made to the admission wards. There the new patients are met and are acquainted with the fact that the hospital has a library. Very often a book or magazine to read during the first hard and restless hours in a hospital will help to make the patient more comfortable.

Interest in the reading of books can be stimulated directly and indirectly. The direct methods are having your library open as much of the time as possible, and constant visits to the wards. Patients should be encouraged to visit the library and select their own books. This is something they can do on their own initiative, which is not true of other activities. The library is the least institutionalized spot in the hospital, and half an hour spent in looking over the books and magazines, at will, gives the patients a sense of freedom they appreciate and by which they benefit. Often just the sight of books is enough to create a desire for something to read. Patients should be allowed to take anything they want from the library and keep books as long as they wish. In the library they should always find some one ready and able to help them, if necessary. Ward visiting is most important. There you can talk with each patient, individually, and try to find out what might interest him. Your approach to the patient should be friendly and natural. These people are out of tune with the world and, although at times they may not show it, they do appreciate thoughtful attention. If they want to talk about themselves and their troubles, be a quiet listener. You will often gather information and establish a friendly relation, in this way, that will be of great value to you in getting the patient to read. The patients can be divided into two main groups, the

elated or active, and the depressed or inactive. The elated patients will tell you of their likes and dislikes without much effort. You will know at once whether they are interested in mystery stories, poetry, French history, or architecture. Many of this group will read without much urging, because they are looking for something with which to occupy their time. A good deal of restlessness can be worked off in the reading of a good story. With the depressed patients it is quite the opposite. They are not only depressed but, as a rule, apathetic and withdrawn. They do not wish to talk and have lost interest in almost everything. Before you can hope to do anything for these patients you have to win their confidence and make them feel that you are genuinely interested in them. After many quiet and friendly visits, they generally show some signs of interest. A good plan with these patients is to leave, in the room, two or three books that you feel might appeal to them. Sometimes this brings about the desired result.

The indirect methods of getting patients to read are the ward libraries, reading to groups on the ward, through information given by doctors and nurses, and by other activities carried on in the library, not strictly of a library nature. Ward libraries should be given careful attention. Many patients who will not come to the library, or take a book directly from you, will read if books are left on the ward. The general make-up of the ward should be studied, and a selection of books left there that you feel will be of interest to the group. As a rule the books may be left for two weeks, but where you find a fair amount of reading going on, it is well to change them every week. Nothing is quite so uninviting as a stale collection of books. Not long ago, on one ward, four men were reading Maurois's biography of Disraeli. One would put it down for a short time and another would pick it up. Three of these men never come to the library. News of a good book travels fast, and patients recommend books to one another. Reading to a group on the ward is often a very good way of awakening an interest in some kind of book. If the story read aloud has been enjoyed, you will find several ready to read by themselves. After reading for an hour on one of the wards the other day, one of the group wanted to know if she could not keep the book in her room until I came back to finish it. She had gotten so interested in the story that she had to read a bit for herself. Also in reading to a group you are keeping a number of restless patients quiet and relaxed, for a time, which is of real therapeutic value. The doctors who are in very close contact with the patient can give you helpful information as to what certain patients might read. Whenever in doubt about what a patient should read, consult his doctor. Sometimes a certain trend of reading is suggested for a patient by his doctor. All this is most helpful and any suggestions made should be carried out with the greatest care.

The nurses can also help in letting you know when patients express a desire for reading. This is particularly true of the disturbed wards where little reading is usually done. Requests for books on disturbed wards should be filled at once. It is in attending to such requests immediately that the greatest good can be done. The interest of these patients is not sustained for long, and, if it is not satisfied, may disappear altogether. Once a week there is an afternoon tea in the library, which has been found to be not only of value in stimulating an interest in the library, but

also a valuable social activity. Five or six women patients take charge of the tea, and heartily enjoy the naturalness of the occasion. The tea is held on a visiting day so that relatives and friends may drop in. This affair helps to make the patients feel that the library is a friendly, social place, to which they enjoy coming.

In certain cases, daily reading with the patient has been found beneficial. These patients need a great deal of personal attention. If left to themselves they do almost nothing. The patient is brought to the library and, if possible, gotten to choose his own reading. As a rule he is willing to read with some one, but will not read alone. The patient should do all the reading. One boy of sixteen who has been in a disturbed state for some time is now reading a group of simple stories on Greek mythology. He does nothing when left to himself. Another boy of twenty-two, whose power of concentration is very poor, I found was interested in aviation. He has just finished reading aloud Lindbergh's "We." He has enjoyed it, and feels quite proud of the fact that he has read a book through. A woman patient, a former trained nurse, who spends most of her time in idleness, has read a life of Florence Nightingale. The object of the daily reading is to get the patient to do something constructive and to help him concentrate, if only for a short time each day.

Reading for patients in a mental hospital is, first and foremost, for pleasure and recreation. In selecting books, this idea should be held firmly in mind. A man or woman engrossed in a good story or book of travel is relaxed and at ease. They are, for the time being, removed from the immediate world, with its trials and complications, into a pleasant one of fact or fancy.

Books can be a very helpful source of information about patients. What do they read and how is it read? Are they interested in imaginative or realistic literature? Are they seeking excitement or romance in their reading? Is it the bizarre and fantastic which interests them in books or the more thoughtful poetry, essays and letters of great thinkers? Do they take an interest in reading about the active, colorful lives of adventurers and people who have occupied commanding places in history? Is it the scientific or artistic literature which gives the most satisfaction? Are the books read through or just skimmed? Is reading giving real pleasure or just helping to pass the hours away? We reveal in what we enjoy reading a great deal about our inner lives. Books bring many of us into contact with an ideal world which we cannot attain in every-day existence. One young man who, for years, has been working in an uncongenial atmosphere with absolutely no time for reading, is now enjoying a world of flowers and gardens. He is for the first time reading about the things he loves. Another man, whose interest in almost everything is very low, is reveling in a comprehensive history of chess. He is not only reading about chess in all ages and countries, but is making different sets of chessmen from the illustrations in the book. For over a month, this book has kept him occupied for several hours a day. The humor of the "Pickwick Papers" is giving another young man real pleasure. He has had the book for months and enjoys reading a little every day. One woman, whose life has been a busy one, but whose appreciation of good literature is keen, is finding the essays and letters of R. L. Stevenson satisfying reading.

The library in a mental hospital

should contain books on almost every subject. You will be asked for books on such varied subjects as etymology, business arithmetic, music, chemistry and many others. Books on religion, medicine and psychology should not be on the open shelves of a hospital library. If books on these subjects are requested by patients, the sanction of the doctor in charge of the case must be gotten before such requests are filled. Try to stimulate an interest in the more objective type of book such as travel, biography and adventure. Always remember, when selecting books for mental patients, that they are restless and that their power of concentration is poor. The interest in the story must be awakened in the first chapter. They will not wade through four or five chapters in order to find the main theme of the story. The general educational and social level of your community should be studied. Only by paying careful attention to this will you be able to select books which will be of the greatest general interest. You will find in the east where the population has been settled for generations, very little interest in stories of pioneer life, or books about the far west, or north. You will find much more interest in historical background and in books about Europe and South America.

Reading is not only a normal recreation but one of the best known methods of helping the stream of thought to flow in an orderly manner. When one is reading with interest, the mind is functioning normally. The power to concentrate on something is being stimulated. Because of these facts, the library has a very definite and useful place as one of the therapeutic activities of a mental hospital.

Diphtheria

1. Toxin-antitoxin is used to give long-time, for all practical purposes permanent, protection against diphtheria. It is safe, harmless and does result in a high degree of protection against diphtheria.

2. Toxin-antitoxin does not give immediate protection. It takes from eight weeks to six months before protection is fully developed. The toxin-antitoxin treatments consist of three doses, given one week apart. Approximately 80 per cent of the children given this course of treatment are rendered immune within six months, the remaining 20 per cent will need a second series of treatments.

3. The Schick test is a scientific means of determining whether or not protection against diphtheria exists. It does not, itself, give any protection whatsoever. It should be given to all children, six months after toxin-antitoxin has been given. This is particularly important because, as was said, approximately 20 per cent will need a second series of treatments before protection is obtained and the Schick test is the only means of determining which these children are.

4. Toxin-antitoxin should not be confused with antitoxin. Antitoxin is used for the cure of a case of diphtheria and for the protection of persons who have been definitely exposed to the disease. It gives only temporary protection for two or three weeks or, at best, a month; it is no good thereafter.

5. An attack of diphtheria does not insure against a second attack. Simply because you have had diphtheria is no assurance that you will not have it again. Many people have diphtheria more than once.

6. Toxin-antitoxin should be given to all children between six months and ten years of age, and six months later a Schick test should be made.—From the *Weekly Health Review* of the City of Detroit Department of Health, December 8, 1928.

A Study of the Nursing Care Given to Mental Patients in the Cook County Hospital

The study which follows was presented in the class in Ward Administration conducted by Gladys Sellew, Assistant to the Dean, at the Illinois Training School for Nurses. The study was prepared by Ethel A. Brett, a head nurse in the Psychopathic Hospital, under the direction of Marion J. Faber, Assistant to the Dean, in charge of the psychopathic nursing instruction and service. Dr. Francis J. Gerty, Superintendent of the Psychopathic Hospital, also coöperated in editing this study.

IN order to give an adequate picture of the nursing care of mental patients in a psychopathic hospital, it is necessary to explain the functions of the medical psychiatric staff and the functions of this particular type of hospital.

The Cook County Psychopathic Hospital serves as a detention house between the court and the state institution for the mentally diseased. The psychiatric medical staff establishes diagnoses for presentation to the commission in lunacy and sorts out the exceptional cases which, under a comparatively short period of medical treatment, may show improvement and hence may not require commitment to a state institution, which means loss of citizenship. In addition, the members of the staff give advice to relatives and friends as to the best future policy in the treatment of the patient as well as coöperate with social agencies and, when necessary, correct their viewpoints as regards the expediency of admitting certain patients to the psychopathic hospital. The staff also aims to cooperate with the various municipal courts of the community.

With the introduction of a better equipped medical and nursing staff, it has been possible to give more adequate medical and nursing care and more humane attention to all the needs of the patient. In the nursing care of mental patients, cleanliness, proper elimination, adequate nourishment and administering of sufficient fluids is being emphasized.

The day pictures presented are those used in four typical wards, two of which differ widely as to the condition of the patient. It has been found rather impracticable to make time studies, because nursing procedures strictly applicable to mental nursing cover such a wide variety of range in time, depending on the type of patient and the condition of the patient on succeeding days.

Day Picture

Men's Ward A i—Disturbed and Receiving Wards.

Women's Ward A ii—Capacity, 22 patients each.

Cook County Psychopathic Hospital,
Chicago, Illinois

A. M.

7.30 Make first rounds. (Head nurse and students.)
Check up on
1. Physical and mental condition of patient.
2. Voiding and defecation.
3. Continuance or removal of or application of any form of restraint, ordered during the night.
4. Transfers to be made to B i or B ii.

8.00 Give out list for urine specimens to attendants.
Give q. i. d. and q. 4-hr. medications.
Cleanse mouths of all patients.
Give fluids.
Offer bedpans and urinals or take patients to the toilet.
Give tub baths to all patients whose condition permits.
Give bed baths to sickest patients with special care to backs.
Morning toilet for patients not having bed or tub baths.
Make all beds and change linen as necessary.

Verify with the attendants, bruises and marks on patient.

9.00 Give q. 3-hr. medications.
Give fluids to dehydrated patients.
Make rounds with resident physician.

9.30 Give enemas as ordered.
Take q. 4-hr. rectal T. P. R. of all patients to have continuous baths or packs.
Start continuous baths or packs as ordered.

10.00 Give b. i. d. medications and p. r. n. treatments.
Take q. 4-hr. rectal T. P. R. of all patients.
Give fluids and nourishments.
Clean and cut nails of patients.
Give special cleansing of mouths of sickest patients.
Record observations of physical condition, behavior and mental attitude of patient.

11.00 Offer bedpans and urinals or take patients to the toilet.

11.30 Serve dinner and special nourishments.
Feed sickest and negativistic patients.
Observe how food is taken by all patients and record amounts.

NOON

12.00 Give q. 4-hr., q. 3-hr. and q. i. d. medications and treatments.
Cleanse mouths of sickest patients.

P. M.

1.00 Check up on urine specimens.
Offer bedpans and urinals or take patients to the toilet.
Give fluids to all dehydrated patients.

2.00 Give t. i. d. medications.
Give fluids.
Take q. 4-hr. T. P. R.

3.00 Give q. 3-hr. medications.
Give fluids and nourishments to sickest and dehydrated patients.
Recording.

4.00 Give q. 4-hr. and q. i. d. medications.
Give fluids.
Offer bedpans and urinals or take patients to the toilet.

4.30 Serve supper to all patients.
Feed sickest and negativistic patients.
Observe how food is taken by all patients and record.

5.00 Give evening care to all bed patients.
This consists of
1. Sponging faces, hands and washing backs.
2. Application of camphorated ointment or alcohol to backs.
3. Special care of any pressure sores.

6.00 Give q. 3-hr., t. i. d. and b. i. d. medications.
Take q. 4-hr. T. P. R.
Give fluids.
Check up on any restraint ordered during the day.
Recording.

7.00 Give nourishments and fluids to sickest and dehydrated patients.
Cleanse mouths of sickest patients.
Offer bedpans and urinals or take patients to the toilet.
List urine specimens not obtained.

8.00 Give q. 4-hr. and q. i. d. medications.
Make patients comfortable.
Remove all restraints possible.
Give fluids.
Start continuous baths or packs for disturbed patients as ordered.

9.00 Give q. 3-hr. medications and treatments.
Give fluids to dehydrated patients and nourishment to sickest patients.

10.00 Take q. 4-hr. rectal T. P. R.
Give p. r. n. sedative medications to restless patients.

11.00 Observe patients and check up on restraints.
Change involuntary patients with special care of backs.
Give fluids to dehydrated patients.

12.00 Give q. 3-hr. and q. 4-hr. medications and treatments.
Give fluids to dehydrated patients.

A. M.

2.00 Take q. 4-hr. rectal T. P. R.
Give p. r. n. medications.
Change involuntary patients with special care of backs.

3.00 Give q. 3-hr. medications and treatments.
Give fluids to all dehydrated patients.

5.30 Check up on any restraint ordered during the night.
Offer bedpans and urinals or take patients to the toilet.
Take q. 4-hr. rectal T. P. R. of all patients.
Give early morning care to all patients.
This consists of
1. Cleansing mouths.
2. Washing faces and hands.
3. Changing linen of involuntary patients and washing backs.

6.00 Give q. 3-hr. medications and treatments.

6.30 Serve bed patients.
Feed sickest and negativistic patients.
(All eating should be observed and amounts of food taken, recorded.)

Personnel—Wards A i and A ii, Disturbed and Men's and Women's Receiving Wards

(Capacity, 22 patients)

1	Head nurse at 48 hr. per week	Total head nurse time	48 hr.
2	Graduate nurses at 48 hr. per week	" graduate nurse "	96 "
	1 Graduate nurse from 3.30 p. m. to 11.00 p. m.		
	1 Graduate nurse from 11.00 p. m. to 7.00 a. m.		
2	Student nurses at 46 hr. per week	" student nurse "	92 "
18	Attendants at 48 hr. per week	" attendant "	764 "
	3 Receiving and bathing new patients and listing and caring for clothing.		
	9 Caring for patients in open wards.		
	3 Caring for patients in private rooms.		
	3 Giving morning baths. (Bed baths, tub baths, and hydrotherapy treatments.)		
23		Total "	1,000 hr.

Day Picture

Ward B i Women—Capacity 46 patients
Ward B ii Men— " 47 "

Cook County Psychopathic Hospital,
Chicago, Illinois

ON both these wards are the patients who have been transferred from the receiving and disturbed wards. These patients are of two types: those who are acutely ill and need the most careful medical and surgical nursing and treatment, and patients who have become less disturbed but still require careful observation.

A. M.

7.30 Make first rounds. (Head nurse and students.) Check up
1. Physical and mental condition of patients.
2. Voiding and defecation.

Verification with attendants of bruises and marks on patients.
Serve special diets.
1. High caloric.
2. Salt free.
3. Diabetic.
4. Pernicious anemia.
5. Pellagra, etc.

8.00 Pass q. i. d. medications.
Give q. 2-hr. and q. 4-hr. treatments.
Take morning temperatures (mouth), pulse and respiration of ambulant patients with observations on behavior and physical condition.
Cleanse mouths of all patients.
Offer bedpans and urinals or take patients to the toilet.
Give daily bed baths to sickest patients. Give bed or tub bath to other bed patients three times weekly.
Give morning care. This consists of
1. Sponging of faces, hands, and washing and rubbing backs of patients not having bed or tub baths.

Make beds, changing linen as necessary.
Give water to all patients.
9.00 Pass q. 3-hr. medications.
Give q. 3-hr. treatments.
Send ambulant patients to shower room for cleansing baths or hydrotherapy treatments.
Care for finger nails of all patients.
Give fluids and nourishment to dehydrated or sickest patients.
Send ambulant patients to occupational therapy department as ordered.
9.30 Make rounds with resident physician.
10.00 Give b. i. d. and t. i. d. medications.
Take q. 4-hr. T. P. R. (rectal).
Give q. 2-hr. treatments.
Give fluids to all patients.
Give special treatments such as enemas, continuous baths and packs as ordered.
11.00 Give fluids.
Offer bedpans and urinals or take patients to toilet.
11.15 Prepare and serve special diets and give nourishments.
Feed sickest and negativistic patients.
Serve bed patients.
11.30 Serve ward diet in dining room to ambulant patients. (All eating should be observed and amounts of food taken recorded, and an effort should be made to classify patients.)

NOON

12.00 Give q. 3-hr. and q. i. d. medications and treatments.

P. M.

1.00 Give fluids to all dehydrated patients.

2.00 Give q. 2-hr. and t. i. d. medications and treatments.
Take q. 4-hr. T. P. R. (rectal).
Send ambulant patients to occupational therapy departments as ordered.
Give fluids to all patients.

3.00 Give q. 3-hr. medications and treatments.
Serve nourishments and fluids to sickest patients.

4.00 Give q. i. d. and q. 4-hr. medications.
Give q. 2-hr. and q. i. d. treatments.
Offer bedpans and urinals or take patients to the toilet.
Give fluids to all patients.

4.15 Serve special diets.
Feed sickest and negativistic patients.
Serve bed patients.
Serve ward diet to ambulant patients in dining room. (All eating should be observed and amounts of food taken, recorded.)

5.00 Give evening care to all bed patients. This consists of cleansing mouths, sponging faces, hands and backs; rubbing backs with alcohol or camphorated ointment.

6.00 Take q. 4-hr. T. P. R.
Give q. 3-hr. and t. i. d. and b. i. d. medications.
Give q. 2-hr. or q. 3-hr. treatments.
Pass fluids to sickest patients.
Complete recording for the day.

7.00 Give fluids to all patients.
Offer bedpans and urinals or take patients to toilet.
Make patients comfortable for night.

8.00 Give q. i. d. and q. 4-hr. medications and treatments.

9.00 Give q. 3-hr. medications and treatments.
Give fluids and nourishments to all dehydrated and sick patients.

10.00 Take q. 4-hr. rectal T. P. R. of sickest patients.
Give fluids to all patients awake.
Give p. r. n. sedative medications.

11.00 Observe patients and change involuntary patients.

12.00 Give q. 3-hr. medications and treatments.

A. M.

2.00 Take q. 4-hr. rectal T. P. R. of sickest patients.
Change involuntary patients with special care of backs.
Give fluids and medications p. r. n.

3.00 Give q. 3-hr. medications and treatments.

5.30 Take rectal T. P. R. of all bed patients.
Pass urinals or bedpans and take patients to toilet.
Give early morning care to all bed patients. This consists of cleansing mouths, washing faces, hands; caring for pressure sores; washing backs and changing linen of involuntary patients.

6.00 Give q. 3-hr. medications and treatments.
Dress ambulant patients and assist with morning toilet.

6.30 Feed sickest and negativistic patients.
Serve bed patients.
Serve ambulant patients in dining room. (All eating should be observed and amounts taken recorded.)
Treatments consist of: Surgical dressings and irrigations. Tube feedings. Special care of backs. Care of pressure sores. Cleansing of mouths. Hydrotherapy treatments. Continuous baths. Packs. Therapeutic sponges. Massage and rubs. Hypodermoclysis. Proctoclysis.

Duties of Student Nurses

Rectal temperatures } pulse and respirations.
Mouth temperatures }
Medications.
Surgical dressings.
Care of pressure sores.
Massage and rubs.
Hydrotherapy treatments (under supervision).
Enemas to sickest patients.
Record of medications.
Treatments and temperatures.
Record observations on patient's behavior, attitudes and symptoms.
Feed } Sickest patients.
Negativistic patients.
1. Spoon feeding.
2. Assist doctor in tube feedings.
3. Forced feedings.
Prepare special diets.
Administer fluids and nourishments.
Assist in spinal punctures.
Morning and evening care with special attention to backs of sickest patients.
Bed and tub baths.
Care of involuntary patients.
Proctoclysis.
Assist with hypodermoclysis.

Personnel—Wards B i and B ii (Capacity: 94 patients)

2	Head nurses at 48 hr. per week. 7.30–3.30 or 7–1 and 4–6.30	Total head nurse time	96 hr.
3	Graduate nurses at 48 hr. per week	" graduate nurse "	144 "
	1 Graduate for relief of head nurses 7.30–3.30		
	1 Graduate nurse 3.30–11.30 p. m.		
	1 Graduate nurse 11.30–7.30		
6	Student nurses at approximately 46 hr. each per week	" student nurse "	276 "
9–10	Attendants on each shift 7.30–3.30, 3.30–11, 11.30–7.30		
31	Attendants at 48 hr. per week	" attendant "	1,488 "
	6 Attendants for care of patients in day room and ambulant patients' dormitory.		
	9 For care of patients in four- and seven-room bed patients' wards.		
	6 For care of patients in private rooms.		
	6 For care of clothes room and transferring patients to convalescent wards or (in case patients require restraint) to violent wards.		
	4 For relief, x-rays, clinics, etc.		
42		Total "	2,004 hr.

Duties of Attendants

Rectal temperatures } pulse and respirations.
Mouth temperatures }
Enemas.
Morning and evening care.
Bedpans and urinals.
Patients to toilet.
Making beds.
Care of involuntary patients.
Administering fluids and nourishment.
Serving of meals.
Tub and bed baths.
Hydrotherapy treatments (under supervision).
Care of backs.
Order of ward.
Escorting patients when transferred to other wards, to clinics, x-ray, baths, or to occupational therapy.
Receiving of patients, giving baths and care of clothing.
Obtaining urine specimens and taking to laboratory.
Holding for spinal punctures.

Continuous Bath

As Given at the Cook County Hospital, Chicago

A CONTINUOUS bath is an immersion bath, given generally in the treatment of very active and excited mental cases. It comes under the heading of hydrotherapy, which relates to the application of water at definite temperatures and by exact procedures to the skin, or mucous membrane for the prevention of disease, or the treatment of the sick.

The continuous bath is used to produce a sedative effect and to eliminate poisons from the body. It will also reduce temperature and has a particularly good effect upon the skin. The warm water keeps the skin soft and active, and thus any tendency to the development of bed sores is largely prevented.

The continuous bath is of great value

in cases of alcoholism, drug addiction, toxic psychosis, manic excitement, general paresis (for prevention of bed sores), insomnia, and other phases of agitation and excitement.

Precautions

1. The temperature of the water should be 97 degrees or 98 degrees.
2. If the patient has a temperature of 103 degrees or above, the bath should be started at 101 degrees or 102 degrees and gradually brought down, within three-quarters of an hour, to 98 degrees. If the patient is in a good physical condition and does not react favorably to a temperature of 98 degrees, the temperature may be reduced to 96 degrees, and some authorities claim that it can be reduced to 92 degrees, or even lower, under certain conditions.
3. Never leave the room. (The patient may put his head under water.)
4. Check the temperature of the water with a thermometer, frequently.
5. The room should be quiet.
6. No talking to the patient, except when absolutely necessary.
7. Push fluids.
8. Apply ice compresses to the head.
9. Observe the patient closely. Take pulse every half hour. Watch for shock.
10. Avoid chilling upon removal from tub.

Equipment Needed for Continuous Bath

1. A bathtub long enough to allow the patient to lie at full length comfortably. The tub should be surrounded with gas pipe frame with hooks attached. The amount of water and the temperature of the water for the tub should be controlled by faucets and a thermostat. There should be a waste pipe where water is tested before filling the tub.
2. Two canvas hammocks, the one used on the upper side having an opening for the head.
3. Two bed spreads.
4. Sheet, if restraint is needed.
5. Pan of ice and water.
6. Compresses.
7. Towel.
8. Drinking cup.
9. Pack pins.

Procedure

1. Adjust the bottom hammock and fasten with hooks to frame on bathtub.
2. Fold the spread, lengthwise, and lay over the hammock.
3. Secure folded spread by means of pack pins to frame around tub.
4. Place the patient on the folded spread.
5. Adjust the upper hammock and fasten with hooks to tub.
6. Place folded spread for pillow under head.
7. Place towel around neck.
8. Test water in waste pipe for temperature, and turn on water until it comes up to the patient's chin.
9. Place the thermometer at the head of the tub for safety.
10. Apply ice compress to the head.
11. Force fluids.
12. The patient may remain in the bath from one-half hour to three days.
13. If the patient is kept in the bath for long periods, he should be taken out and oiled every eight hours.
14. Remove patient from tub; have the room warm and use blankets to avoid chilling.
15. A dry sheet wrapped around the patient is the best means of drying. Dry by rubbing with gentle strokes away from heart.
16. Put the patient to bed in a warm room. Give fresh air, but avoid drafts.

The Office Nurse

MARIE E. MILLER, R.N.

ALMOST every subject which deals with nursing has been discussed from all angles in the nursing journals and great benefit has been derived therefrom. There is one phase of nursing, however, which has not been discussed and my purpose is to present this to the nursing world. I wish to introduce the office nurse, a representative of our profession who has been overlooked. She should be regarded with respect by the nursing profession as many splendid nurses are engaged in the various branches of this work.

One of my friends doing office nursing was quite amused when a member of her family asked when she was going to do real nursing again, and many have that opinion. Office nursing is either considered a position without nursing ideals, or it is a subject which is not even mentioned, as in Dr. Burgess's book, "Nurses, Patients and Pocketbooks." In all our publicity for nursing education we are simply overlooked, we do not exist. The private duty nurse has come into her own; she has arrived; the public health nurse is well established, but the office nurse is still groping, waiting to be classified. She is steadily growing in numbers, which must mean that nurses feel satisfied with what this field has to offer and that there is a demand for this type of work. The regular hours of office nursing have their appeal, especially to those who may have done twelve- or even twenty-four-hour duty without relief. Although more regular in hours, the clock is not watched too closely, and overtime is not considered a crime.

At one time office nurses were very much underpaid and were thought to have accepted a less dignified position in the nursing world, but the lack of pay at that time was compensated by better hours, a chance to live. This difficulty, however, has been overcome: the physician now demands well-trained assistance, and he considers in turn that his nurse has become a necessity and is entitled to pay commensurate with her training and skill.

Another argues that one loses that finer touch, the contact with the patient, that is dear to the nurse's heart, but the office offers the opportunity of meeting many patients every day, many patients who are ill and many who think they are ill, all to be met in a professional and understanding way. Your contact is everlasting—they are forever coming and your interest is kept constantly alive, as each one has his individual problem.

A physician once said to me: "I need a nurse in my office, and above all things she must have tact and be able to meet the public." And it must be an important attribute, this meeting of the public, the ability to give a word of encouragement to some poor soul who is simply frightened to death over some real or imaginary trouble. Tact is a simple word but means much; it may bridge over a most difficult situation, it may make a friend for life. We are all human, after all, and the little kindnesses extended through interest and the hope of helping mankind, do much for those physically and mentally sick.

The discreet nurse is usually the successful one. This is indeed true of the office nurse, as discretion is one of the most important factors of her position; without it she had better take up a different branch of nursing. Indiscretion on her part might easily be responsible for serious trouble for the

physician with whom she is associated. An unguarded word or even a look will sometimes serve to undermine the confidence of the patient, or lead to a misunderstanding.

I was brought to a realization of the absolute necessity of a sense of humor in the office nurse by the remark of a patient in the office where I work. This patient, a man of intelligence and wealth, was of the repulsive type. I found it so difficult to conceal my feeling of dislike, that he sensed it and casually remarked: "You would make a first-class assistant to an undertaker." In great surprise I inquired why he specified that particular walk of life. He replied, "Because you never smile." Since this experience I have endeavored to counteract the depressing effect which certain patients have upon me and treat it as a humorous situation, never allowing the ridiculous to detract, however, from my professional attitude or sympathy with their troubles. I have felt quite grateful to the gentleman of repulsion and wealth, and ever since this experience I have liked him better.

In looking over our professional activities, we find the office nurse qualifies, and has proved herself capable of holding office in the different organizations. Perhaps we too have arrived, and the explanation for our not having been classified, is due to the fact that we are a new departure.

The office nurse is most versatile. We find her in every type of office, as far as the medical specialties go, making a success of each one. She must keep up with the latest technic, as often new procedure is first developed in the office. A knowledge of stenography is a very valuable asset to the office nurse, for she is often called upon to take medical histories, compose letters to patients, and assist in the preparation of medical papers. Her knowledge attained in the school of nursing must not be merely perfunctory. The successful office nurse must have wide and accurate knowledge of scientific medicine. She has proved herself the trusted assistant of the physician and has become a vital and necessary part of the up-to-date office.

The public demands us, it likes us, we give it an added assurance that all is well. I believe the office nurse has found her place and will continue to live.

Increasing the Mother's Milk Supply

ONLY a few women are unfortunate enough not to be able to nurse their babies, but there are a great many who think they can't. Assuming that the mother is anxious to nurse her baby, are there any things that she can do to increase her milk supply if it should be scanty? First—she should have an abundance of good food and plenty of fluid. Her diet should be a general one of meat, eggs, potatoes, cereals, fresh vegetables, fruit, bread and butter, and it may be a good thing for her to take an extra meal of milk and fruit at bedtime as well as to drink a glass of milk at each meal. She should always drink plenty of water. The other important thing necessary to increase the flow of milk is to use the breast often. The less there is, the more often she should nurse especially at first until the flow of milk is established. If a baby is nursed each time on alternate breasts, and then only every four hours, it means that each breast will be quiet for eight hours instead of each being stimulated perhaps every two or three hours. Only too often is the baby accused of having colic when as a matter of fact it is only hungry. It is perhaps impossible to set down a general rule for nursing every baby. Some may do better on four-, some on three-, and some even on two-hour intervals. If there is evidently an abundance of milk and the baby is strong and husky and nurses well, it may be that a four-hour interval on one breast at a time, would be the best schedule for that particular baby. The scales will tell the story.—Health Bureau Bulletin, Rochester, New York.

The Lutheran Hospital Library

PHOEBE M. KANDEL, R.N.

A LIBRARY was provided in the plans of the new Nurses' Home of the Lutheran Hospital in York, Nebraska. It is located on the south side of the building; in dimensions it is 16 feet by 20 feet. The built-in bookcases line the entire east wall to a height of ten feet. There is shelf space for about 1,000 books, protected from the sand and dust of which this part of the country has considerable during the summer months, by glass-paneled doors. The library system adopted for the cataloguing of the books is that devised and recommended by Blanche Pfefferkorn.[1]

LUTHERAN HOSPITAL NURSES' HOME

The furniture of the room consists of a long oak table, with comfortable chairs which are stained the same as the bookcases and the wood finishing of the room. The journals for the month are kept on the table, the remainder in the bookcase. A pedestal reading lamp with a large shade is not visible in the picture. On the north wall is a large sized picture of Florence Nightingale; on the south wall, the picture of Isabel Hampton Robb.

This room is always accessible, for both reference work and reading of the journals. The superintendent of nurses also uses this room for supervised study periods.

This building was opened the fall of 1927. The students' rooms are of

[1] *Modern Hospital*, December, 1920.

good size, all equipped with two beds, dresser, table, closets, chair and rocker. There is a living room directly opposite the library, separated by a hallway; there are double doors to each room that may be closed.

LIBRARY

Desire to Live

BY JOHN EDWARD ALLEN

I WOULD not have my life be one of bliss—
Untouched by heartache, agony, despair—
A pale, anemic thing. My nightly prayer
Is that with each new day I shall not miss
High venturings, nor undeserve the hiss
Of envious human moles who never dare
To touch off rockets in their souls and flare
Above their deepening grooves.

O grant me this:
That I shall scale Life's peaks, explore its glooms,
Know mountained ecstasies, deep-valleyed pains—
That when my last red sands by Time are sieved
And Fate has struck my sinews from her looms,
I shall have earned three words o'er my remains
Besides was born and died—
"Between he lived!"

The March of Preventive Medicine[1]

KONRAD E. BIRKHAUG, M.Sc., M.D.

WITH rare exceptions, the world's history presents no more fascinating studies than man's attempt to know the causes of contagious diseases and to discover methods and means for immunizing mankind against the ravages of certain infections. Prevention rather than the cure of disease is seriously considered more economical in our present civilization, and the stride made in preventive medicine continues to command both respect and admiration throughout the entire civilized world. This address is largely concerned with the progress made against infections to which the majority of mankind are subjected, namely, the contagious diseases. I have arbitrarily chosen the most conspicuous and recent advances made in (1) tuberculosis, (2) diphtheria, (3) measles, (4) scarlet fever, (5) erysipelas, (6) whooping cough, (7) poliomyelitis and encephalitis, (8) rheumatic fever, and (9) yellow fever. Much because of the extension of laboratory opportunities for original investigative work in recent years and the host of men and women engaged in medical research, a tremendous amount of new literature has been made available. The rapidity with which this literature is accumulating makes it almost imperative that from time to time a résumé should be made for the benefit of those to whom such literature is inaccessible. The following brief notes are compiled in order to bring you, so to speak, up to date with the work going on in laboratories throughout the world on diseases in which you as nurses should have a peculiar interest, or in case of bitter forebodings about the progress in preventive medicine, which you unwarrantedly fear will rob you of your "bread and butter," you should have at least a burning sense of professional curiosity.

Tuberculosis.—Among the major diseases of man the most common and disastrous is tuberculosis, both among children and adults. It has been estimated that of all diseases, about 10 per cent in the United States and 12 per cent in Europe are due to tuberculosis. Examination of different groups of children of school age reveal that at least 30 per cent present definite evidence of tuberculosis. During the most useful years of life, which range from 15 to 40 years, the heaviest toll of lives is taken by tuberculosis. It is usually stated that from one-seventh to one-tenth of the civilized population dies from tuberculosis, but the world's mortality from tuberculosis is conceded to be much underestimated. In the United States alone, 160,000 persons die annually of tuberculosis. The distressing fact is that much of this plight might be prevented with proper precautions. It is practically impossible to detail the outlook for the prevention of this disease. Under the present status, authorities state that among 90 million population, 8 million are doomed to die of tuberculosis. It would seem, therefore, that any specific measure for the cure and prevention of tuberculosis would be most welcome by the medical profession. It is certain that no specific treatment exists for tuberculosis. The work of Dreyer with vaccination against tuberculosis with a suspension of tubercle bacilli which had been extracted by hot acetone after treatment with formalin, has

[1] Address delivered before the Alumnae Association of St. Mary's Hospital, Rochester, N. Y., November 5, 1928.

been a complete failure both in the prevention or treatment of tuberculosis. Experimentation on laboratory animals with injections of minute doses of virulent, avirulent and dead tubercle bacilli have aroused exceptional interest in that partial immunity is demonstrable against tuberculosis by these inoculations. The actual use of living and virulent tubercle bacilli has proven very effective, but the hazards of this procedure are too numerous and serious to render it useful in general practice. Petroff is of the opinion that injections of dead tubercle bacilli will accomplish an appreciable degree of immunity against tuberculosis without the risk of inflicting the disease by the vaccination itself.

Few announcements in recent years have aroused more interest and hope than those of Calmette, Guerin and co-workers at the Pasteur Institute in Paris, concerning the protection of laboratory animals and cattle against tuberculosis by immunizing them, soon after birth, with a peculiar strain of the tubercle bacillus called B. C. G. (Bacillus Calmette-Guerin). In 1924 Calmette observed that after 230 successive generations, during 13 years, of a virulent tubercle bacillus grown on potatoes saturated with bile and 5 per cent glycerin, this organism failed to produce tuberculosis in animals although it still produced tuberculin. Animals inoculated with this B. C. G. organism henceforth remained resistant to virulent tubercle bacilli. Calmette and his co-workers sensed the prophylactic possibilities of this mode of vaccination, and it was gradually applied to young children. Since July 1, 1924, 52,772 infants under ten days of age have been given a dose of 10 milligrams of the B. C. G. organisms by mouth. Of this series 3,808 remained in constant contact with tuberculous parents and only 34, or 0.9 per cent, died of tuberculosis. The remaining vaccinated infants lived in non-tuberculous surroundings and none died of tuberculosis. According to statistics presented by Calmette, infant mortality of children under one year of age, and raised by tuberculous parents, holds an average level of 24 per cent and often rises to 70 and 80 per cent.

Although this work has aroused keen enthusiasm, particularly in France and her colonies, it has met with serious criticism in many quarters. The basis upon which Calmette places the value of his work is the statistics given above. It is well known that in Denmark and Germany, only 7.7 and 14.2 per cent respectively of non-vaccinated infants, under one year of age, die of tuberculosis, although they remain in tuberculous surroundings. It is also known that Calmette's autopsy findings in the deceased infants are not absolutely reliable, since the word of the general practitioner in many instances seemed the only criterion on which Calmette's statistics were founded. Another criticism is that the B. C. G. organisms become virulent when injected into animals and man and thus constitute a serious risk of the production of tuberculosis. For these reasons the B. C. G. mode of vaccination as a prophylactic measure against tuberculosis has been discouraged outside of France, with a few exceptions. The opinion of United States and Canadian leading experts is unfavorable to its use. Dr. Petroff writes in the July number of the *American Journal of Public Health* that "in the United States and Canada where the campaign against tuberculosis is made very effective by the use of various sociological and health measures, mortality and infection in

childhood have decreased to a very low level and we cannot see why such a prophylactic measure (B. C. G. vaccine) as advocated by the French investigators should be introduced at present. We believe that watchful waiting is the best position at present in reference to vaccination of infants."

Diphtheria.—Thirty-six years ago, von Behring and Wernicke gave to the world diphtheria antitoxin as a specific treatment for diphtheria. The average annual mortality from diphtheria in the fifteen largest cities in the United States before 1894, was 94.13 per 100,000 population, and in the period between 1920 and 1925 it dropped to 15.39, while in New York City it was 13.47. The 1910 report of the Metropolitan Asylums Board in London states that diphtheria mortality in laryngeal cases, before the introduction of diphtheria antitoxin in 1894, was 62 per cent, while in 1910 it was reduced to 11.7 per cent by means of antitoxin, excluding the cases in which tracheotomy was performed. While other factors may account for the decrease of case mortality, there is sufficient evidence available to show that the enormous reduction in deaths from diphtheria since the introduction of the antitoxin-remedy is indisputable and that it partakes of the miraculous. The question suggests itself why diphtheria is not completely wiped out, since the specific cause, cure and prevention have been known for several decades.

A careful study of deaths due to diphtheria in New York reveals that more than 40 per cent of fatalities occur in cases specifically treated after the third day from the onset of the disease. It is also observed that 10 per cent of these deaths take place because no antitoxin is administered. And it is regrettable to know that in about 35 per cent of deaths from diphtheria, the attending physicians neglected to administer the antitoxin during the first visit to the patient. Much needless criticism has been advanced against the value of the diphtheria antitoxin in all cases of diphtheria. In many instances such aspersion should be thrown rather upon the administration of the antitoxin.

Although the general trend of diphtheria has been greatly reduced in America and on the European continent, yet in recent years large increases of the disease have occurred in Berlin, Paris, Budapest and in many Russian cities. Whereas the average fatality from diphtheria before 1926 was 4.7 per cent in the famous Rudolph Virchow Hospital in Berlin, today it has risen to 25–30 per cent. Dr. Bardach, public health officer at Odessa, Russia, told me personally, last summer, that the average fatality from diphtheria was about 35 per cent throughout Soviet Russia. How can diphtheria best be stamped out as a human infection?

The most efficient preventive measure against diphtheria is active immunization of all young children with toxin-antitoxin. Since about 60 per cent of all deaths from diphtheria occur under 5 years of age, and 35 per cent take place between 5 and 10 years, or 95 per cent of all deaths in children occur under 10 years of age, it seems that absolute prevention of diphtheria should preferably be concentrated upon the pre-school child who stands in the greatest danger of contracting a fatal attack of the disease. Agreement is found among authorities that the ideal time for the administration of toxin-antitoxin is about nine months of age.

Excellent results following extensive immunization of children with toxin-antitoxin are reported from everywhere in the United States. Carefully

analyzed statistics are not accessible from many centers concerning the absolute protection afforded by toxin-antitoxin immunization. The most complete and exemplary effect of active immunization against diphtheria with toxin-antitoxin is reported from Auburn, New York, and Brantford, Ontario. Auburn has a population of 35,700. About 9,000 children have been immunized, or found to be naturally immune, since 1922. The report states that altogether about 12,000 children are under 15 years of age. In 1924 the death rate from diphtheria dropped to 2.7. From March, 1924, until January, 1928, the remarkable record of no deaths from diphtheria is reported. This glorious as well as enviable record was upset this year when two deaths occurred, one in a child and the other in an adult, who were never immunized and to whom antitoxin was administered very late in the disease.

Brantford, with a population of 30,000, has immunized 7,600 children. In 1920 to 1921 the death rate from diphtheria was seven, and in 1922 it had dropped to two. The record reached zero in 1923 and, with the exception of two deaths from diphtheria in 1924, there have been no deaths from diphtheria in this ideal city.

These two instances are the most classic examples of what may be accomplished in preventive medicine when physicians, nurses, and the laymen coöperate with the public health authorities of the community. These are "unique instances not only because the immunization idea is being given a fair test under practically perfect control, but also because, in three years, Auburn and Brantford had not a single death from diphtheria in children or in adults."

Several modifications of the toxin-antitoxin method of active immunization against diphtheria have been suggested in recent years. Peroral administration of killed diphtheria bacilli has been practiced in Germany with the establishment of only slight immunity after from six to seven weeks of immunization. Anti-diphtheritic vaccination with diphtheria toxin subjected to heat and formalin, the so-called "anatoxin" of Ramon, is widely employed in Europe. The results obtained by this almost painless, detoxified substance are very similar to those resulting from toxin-antitoxin. This method is rapidly being employed in Europe and is now being introduced into America. Besides reducing the usual discomforts experienced with toxin-antitoxin, the three injections of anatoxin (0.5, 1 and 1.5 c.c.) turn the Schick test negative in 10 to 30 days in 95 per cent of persons. It takes three to four months to turn the Schick test negative with the toxin-antitoxin method.

Active immunization with toxin-antitoxin is gradually being introduced all over the world, with America leading in this respect. From available records it is not too much to predict that within another decade or two at least 85 per cent of diphtheria will be prevented and at least 90 per cent of patients ill with the disease will be cured. It is also safe to predict that Ramon's "anatoxin" will completely replace the original toxin-antitoxin vaccination.

Measles.—The specific cause of measles remains a mystery today. The ultimate conquest of this disease must necessarily await the discovery of the causal agent. Several claims have been advanced during the last few years that a *Streptococcus viridans* is ultimately linked up with measles and that this green-producing organism can be regularly isolated from the

blood during the eruptive stages of the disease. The most notable work along this line has been done by Tunnicliff and Ferry and Fisher. These investigators firmly believe that the organism isolated by them—for it appears that Tunnicliff's green-producing diplococcus is identical with Ferry and Fisher's "*Streptococcus moribilli*," as well as Duval and Hibbard's measles coccus—is the specific cause of measles. On this assumption they have set about to produce anti-measles sera in goats and horses for the treatment and prophylaxis of measles. A large number of reports on the use of these sera are on hand, and the opinions about the value of these products are not absolutely convincing that a specific remedy is available. Although these studies have aroused keen interest and hopes for the eventual discovery of the true cause of measles, one feels that much more experimental work must be done in order to settle the etiology of measles.

Degkwitz in Munich believes that measles is caused by an ultra-microscopic virus which circulates in the blood-stream of measles patients during the early stages of the disease. He was able to grow this virus in human blood cells and plasma, and proceeded to immunize sheep against it. The immune sheep serum has been used extensively throughout Germany for the prevention of measles. Almost all available reports condemn Degkwitz's claims, since all children under investigation, who were injected with Degkwitz's alleged protective sheep serum during the incubation period, developed measles. Most of these children had severe complications and almost all of them had serum sickness.

In the meantime the widespread prevalence of, and "man's exquisite susceptibility" to measles persist. Together with smallpox and epidemic influenza, measles is considered a most contagious disease. The most unfortunate victims of measles are children under three years of age. During the 1926 and 1927 epidemics of this disease, 17 per cent of all cases were under three years of age, and the mortality in this age group was about 10 per cent. In the United States at least 10,000 deaths take place annually from measles. This figure is admittedly very conservative, since numerous deaths from this disease are listed under pneumonia.

The most reliable mode of prevention of measles is the use of convalescent serum, taken from patients about the tenth day after defervescence. Although Cenci, in 1907, was the first to use convalescent serum in the prevention of measles, Nicolle and Conseil, in 1918, and Degkwitz a few years later, popularized extensively this effective method of prophylaxis. In order to be effective, the convalescent serum should be injected before the fifth day after exposure to measles, and the usual dose is 2 to 5 c.c. injected intramuscularly. About 85 per cent of children are in this manner protected against an attack of measles. If complete protection is not given, the disease is usually greatly modified and the complications seldom occur. This method is practised throughout the world and has met with united approval everywhere.

The handicaps of this practice are twofold. First, it is difficult to obtain large amounts of serum from children convalescing from measles, and large amounts are essential to check the outbreak of epidemics in schools and congested children centers. Second, the passive immunity bestowed is very transitory and is rapidly lost in from six weeks to six months. These

difficulties make it increasingly important that the specific cause of measles should be discovered. With the specific agent unearthed, development of immunization along the lines of those followed so successfully in diphtheria, scarlet fever and erysipelas can be initiated. In the interim, the utmost support should be given to the popularization of the immediate use of convalescent serum to any child exposed to the disease and with a negative history of measles.

Scarlet Fever.—After more than forty years of doubt about the specific cause of scarlet fever, the work of Gladys and George Dick and Dochez, during 1923–1926, definitely established that a special type of hemolytic streptococci, called "*Streptococcus scarlatinae*," is the true cause of scarlet fever. The experimental production of scarlet fever in volunteers was accomplished by the Dicks with a pure culture of the "*Streptococcus scarlatinae*." The Dick test for susceptibility to scarlet fever has been carefully studied throughout the medical world on legions of individuals. The results obtained are irregular. Many reports are available of Dick positive reactions following an attack of scarlet fever, and it is also known that Dick negative reactors have contracted the disease. For these reasons the Dick test is, in certain quarters, held not to be of any reliable diagnostic value. This group of investigators is of the opinion that a Dick positive reaction is only an index of hypersusceptibility to bacterial proteins in general. Undue importance has been attached to these irregularities by Szontagh in Budapest and Fanconi in Zurich, who together with many other investigators deny that scarlet fever is caused by a specific streptococcus. The majority of bacteriological experts, however, believe that the "*Streptococcus scarlatinae*" is the true cause of the disease.

The results obtained with the scarlet fever antitoxin in the treatment of scarlet fever have uniformly been well nigh miraculous. Usually the temperature, pulse and respiration are restored to normal within 18 hours after the intramuscular injection of an adequate therapeutic dose of the antitoxin, and the scarlatinal rash disappears completely within 24 hours. Unfortunately, the incidence of complications has not been markedly reduced by the use of the antitoxin. Because of the high percentage of severe serum sickness following the use of the antitoxin, many authorities believe that this specific remedy should not be used in mild cases of scarlet fever. Many prominent physicians are opposed to this practice and they administer the antitoxin in every case of the disease. The obvious reason for the universal use of the antitoxin is to obviate the strain placed by scarlatinal toxin upon the heart and kidneys. Only the future will settle this moot question.

Active immunization against scarlet fever by means of a series of subcutaneous inoculations of the Dick toxin has been in vogue for the past three years. The usual dosages in this course are 500, 5,000 and 30,000 skin-test doses of toxin injected with ten days interval. The actual duration of active immunity exceeds two years.

Owing to the unpleasant localized and generalized reactions following the injections of the Dick toxin, several attempts have been made to detoxify the Dick toxin, as was done with the diphtheria toxin. The most successful attempt in accomplishing this was done by Larson, by means of sodium ricinoleate. The injection of 3,000 to 5,000 skin-test doses of Larson's detoxified Dick toxin is

attended by little or no discomfiture, and the results obtained are commensurate with those produced by the original Dick toxin.

It has been recommended to inject from 2 to 5 c.c. of the scarlet fever antitoxin intramuscularly as a prophylactic measure in persons exposed to scarlet fever. This passive immunization may avert an attack of scarlet fever, but the immunity established is of very short duration and persists only for a few weeks. If afterwards this person contracts scarlet fever, or any other infectious disease which necessitates the administration of horse serum, he is rendered anaphylactic to horse serum by the prophylactic dose of scarlet fever antitoxin. Serious complications may arise from such ill-advised practice. A better procedure would be to test exposed individuals with the Dick toxin and to isolate the positive reactors during the incubation period of scarlet fever. If the disease is contracted, then is the time to administer the scarlet fever antitoxin.

Although a vast amount of beneficent therapeutic good has been accomplished in scarlet fever in recent years, a complete understanding of the many irregularities in the bacteriology and serology in this disease is not by any means available. A revaluation of all accumulated ideas must shortly take place in view of the recent revival of the study of bacterial allergy in infectious diseases.

Erysipelas.—The work I was privileged to start in 1924 on the etiology of erysipelas eventually led to the production of the erysipelas antitoxin. A number of investigators have demonstrated that this disease yields readily to the proper administration of erysipelas antitoxin. The only unfavorable report has come from Dr. McCann who analyzed 69 cases treated with erysipelas antitoxin. He admits, however, that the obtained results warrant further studies with the erysipelas antitoxin properly controlled. The most notable study on the effect of the antitoxin treatment has been done by Symmers, at the Bellevue and Allied Hospitals in New York. From a study of 705 cases treated with the erysipelas antitoxin, Dr. Symmers concludes that "the antitoxin treatment of erysipelas marks an advance, the results of which are commensurate with those obtained in the treatment of diphtheria. It confers great economic benefit on both the patient and the hospital, the patient's period of disability being reduced by almost 60 per cent. At the same time it effects a notable saving of bed linen and sleeping garments, doing away with the destructive action of ointments and similar local applications formerly used in the treatment of this disease."

The unfortunate part of having sustained one attack of erysipelas is that the disease fails to bestow permanent immunity, such as is the case in scarlet fever. The frequency of recurrent attacks varies between 8 per cent (Birkhaug) and 41 per cent (Firchhinger). Firchhinger, at Munich, analyzed 37,612 cases of erysipelas during 1874 and 1889. By means of a course of subcutaneous injections of the *Streptococcus erysipelatis* toxin-vaccine, I have been able to ward off recurrent attacks for more than two years in a group of persons who for years have suffered with repeated attacks every other month or two.

Whooping Cough.—Whooping cough is one of the most contagious of childhood diseases. There is no positive prevention of this disease. Convalescent serum has been used with a fair amount of good results. Vaccine treatment with stock vaccines has

attained the highest record of prevention as well as therapeutic good during the disease. Many clinicians hold the opinion today that the only reliable method of prophylaxis resides in the vaccine treatment.

Poliomyelitis and Encephalitis.—In spite of Rosenow's claim that a streptococcus is responsible for poliomyelitis and encephalitis and that the antistreptococcic sera he has prepared against these organisms have yielded favorable results, the opinion of experts is opposed to his claims of specificity on the grounds of inadequate experimental data and lack of control studies. The true causes of these two infectious diseases remain mysteries. The use of convalescent sera in these two diseases has proven very successful. In order to make the treatment effective in the preparalytic cases of infantile paralysis, Aycock believes that the serum must be used within 36 hours after the appearance of the first symptoms. He administered from 40 to 50 c.c.; 15 to 20 c.c. intraspinally on each of two succeeding days and the remainder intravenously at the time of the intraspinal injection. About 90 per cent of the cases thus treated fully recovered. The same holds true for the early administration of convalescent encephalitic serum.

Flexner and Stewart's experiments on monkeys indicate that convalescent serum protects against poliomyelitis. These authors suggest the production of passive immunity of children, in the event of severe outbreaks of poliomyelitis and encephalitis. For this purpose they administer from 10 to 20 c.c. of convalescent serum by subcutaneous injection. This passive immunity persists for at least one month and as such wards off an acute attack during an epidemic.

Rheumatic Fever.—It is becoming more and more evident that rheumatic fever is intimately linked with streptococci. The recent studies of Small, Swift, Derick, Hitchcock and myself have added some interesting data to the previously extensive work done on the etiology of this disease. In spite of the dogmatic claim of Small that his "*Streptococcus cardio-arthritidis*" is the true causal agent in rheumatic fever, the crucial proof of strict specificity of any one organism causing rheumatic fever is still missing. My personal belief is that rheumatic fever is not caused by one specific strain, but by a number of readily lyzable streptococcic toxin-producing organisms which render certain tissues in the body hypersensitive to subsequent infections by the same or other streptococcic toxin-producing strains which contain, perhaps, the same sensitizing property as the organism that first sensitized certain tissues. The sensitizing factor may be the nucleo-protein fraction of the non-hemolytic streptococcic cell. Most of the recent studies in rheumatic fever are being conducted along this line of approach, and the future alone will know adequate therapeutic or prophylactic remedies for this dreaded disease of childhood which "licks the joints and bites the heart."

Yellow Fever.—Although conspicuous advances have been made in many other infectious diseases, I must bring this paper to a close by stating a few pertinent and most revolutionizing experiments performed on yellow fever, a disease which you will recall hindered for decades the work started by Ferdinand de Lesseps on the Panama Canal, and which cost one human sacrifice for every cubic yard of excavated soil before the work was finally abandoned by the French. Only recently, these investigations cost the lives of three most eminent scientists, namely, Adrian Stokes,

Hideyo Noguchi and Alexander Young.

It is now definitely established that yellow fever is not caused by a spirochete, as was believed by Noguchi and others. Before his untimely death, Adrian Stokes and his coworkers at Lagos, Nigeria, demonstrated for the first time that yellow fever could be transmitted by the mosquito from man to the Asiatic monkey, "*Macacus rhesus.*" Because of this important discovery—the African monkey is immune to yellow fever—Hindle was able to demonstrate quite recently that the yellow fever virus can be recovered from the liver and blood of the "*Macacus rhesus*" monkey that died from the disease. In drying the infected liver and blood, the virus was found to be markedly reduced in virulence and, when it was injected into susceptible monkeys, it failed to produce a fatal attack of yellow fever. After this initial vaccination with dried infected liver and blood, the monkeys resisted injections with the living virus which contained 10,000 fatal doses of yellow fever virus. After this ordeal the vaccinated monkeys remained healthy and lively.

This is the most hopeful research presented on the yellow fever problem and may, in the course of experimentation, prove to be an effective means of vaccination against yellow fever. If such hope is ever fulfilled, then we may look upon the scroll which bears the names of the many martyrs who fell victims to the elusive virus of yellow fever, in their line of duty to solve its mysteries, and recall the words in the good old Book: "They are dead, they rest from their labors, but their works do follow them."

"The repeated discoveries," writes Dr. Noyes, "of new and unexpected types of phenomena in the physical world make us realize more than ever the limitations of our understanding, they lead us to feel with Tennyson that 'as knowledge grows from more to more, will more of reverence in us dwell.'" And we like to repeat to ourselves the words of a poet-scientist of England (Whetham):

We scatter the mists that enclose us;
The seas are ours and the lands,
The quivering ether knows us
And carries our quick commands.
From the blaze of the sun's bright glory
We sift each ray of light;
We steal from the stars their story
Across the dark space of night.

But beyond the bright searchlights of science,
Out of sight of the windows of sense,
Old riddles still bid us defiance
Old questions of why and whence.
There fail all sure means of trial
And end all the pathways we've trod
Where man by belief or denial
Is weaving the purpose of God.

PUBLIC health is the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health. — From "The Untilled Fields of Public Health," by C.-E. A. Winslow.

State Registration Requirements for Entrance to Nursing Schools

SOURCES: Digest of the Laws of the States Requiring Registration for Nurses and Attendants compiled by Wisconsin Legislative Reference Library, and issued by American Nurses' Association, New York, 1928. List of Schools of Nursing Accredited by State Boards, published by American Nurses' Association, January 1, 1928:

4 years High School

Maryland
Oregon
Rhode Island
Utah
Washington

2 years High School

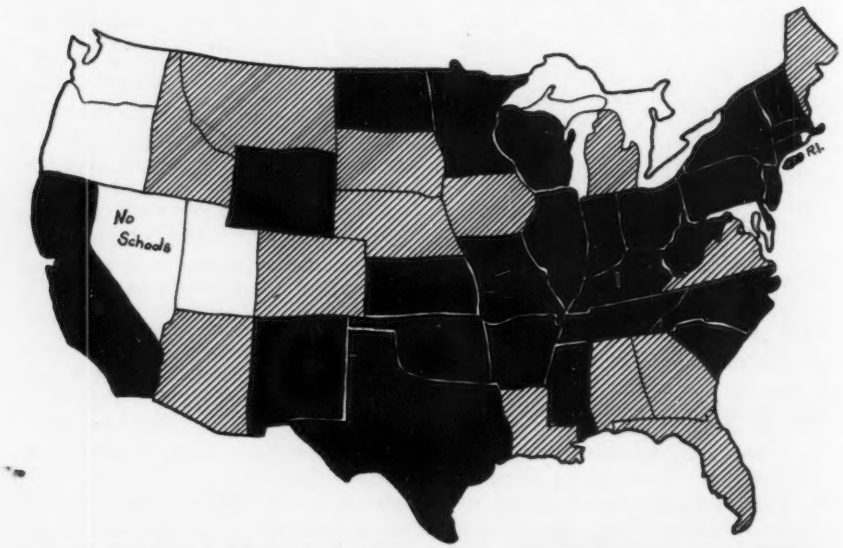
Alabama
Arizona
Colorado
District of Columbia
Florida
Georgia
Idaho
Iowa
Louisiana
Maine
Michigan
Montana
Nebraska
South Dakota
Virginia

1 year High School

Arkansas
California
Connecticut
Delaware
Illinois
Indiana
Kansas
Kentucky
Massachusetts
Missouri
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Pennsylvania
South Carolina
Tennessee
Texas
Vermont
West Virginia
Wisconsin
Wyoming

8th grade

Minnesota
Mississippi



States requiring one year or less of high school education ▬; two years ▨; or four years ▭; for entrance to nursing school

Revision of a Nursing Procedure

Correlating Theory and Practice

GRACE WATSON, R.N.

SOMETIMES the purpose of a nursing procedure seems not to be emphasized as strongly as the technic involved. It is not an uncommon experience to see a student nurse striving to carry out nursing technic, with little, if any, knowledge of its purpose.

The method of teaching how to give a simple enema has been chosen for revision because there seems to be a wide divergence between the theory underlying the technic of the treatment and the practical procedure itself. Also, the treatment is one with which every student nurse is familiar.

The aim has been to increase the student's interest in the scientific aspects of bedside nursing.

It endeavors to show:

1. How emphasis of the important points in nursing technic may be correlated with facts gained in the student's science studies.
2. How a student may be helped to cultivate the habit of associating the technic of nursing practice with the thought of:
   (a) What is the condition of my patient which I am expected to relieve by this procedure?
   (b) What is it that I wish to accomplish?
   (c) How shall I do this particular nursing act in order that I may carry out the physician's orders most successfully?

The object of this lesson is to give the student nurse an understanding of what is involved in the giving of a simple enema, namely:

1. Some of the conditions which make the giving of an enema necessary, and which, if her technic is good, she will assist in relieving.
2. The structure and function of the organs chiefly concerned with the procedure.
3. Selection, proper use and care of materials and equipment.
4. The best way to prepare the patient, and to use the equipment, with the maximum degree of skill, in (a) the economical use of equipment, (b) the safest and most comfortable procedure for the patient.
5. The effect of the procedure on the patient.
6. Opportunity for development of specific desirable qualities in the student; namely, resourcefulness, initiative, intelligent observation, accuracy in recording data, ability to teach health and to help her patients develop health habits.
7. Test of good nursing work.

Enemas defined:

"Enemas or clysters (enemata) are liquid preparations intended for injection into the rectum. There are no official enemas. A simple enema is one composed of cool or tepid water, or of soap and water. For an infant, 1–2 ounces (30.0–60.0 c.c.) may be employed; for a child, 4–8 ounces (120.0–240.0 c.c.); for an adult, 1–2 pints (0.5–1.0 L.)." "An enema may act by distending the bowel mechanically, by softening intestinal contents, or by directly irritating the intestinal walls." (Stevens, "Text Book of Therapeutics.")

Various medicinal substances, such as glycerine, magnesium sulphate, turpentine, ox-gall, etc., are prescribed for specific purposes and are included in the formulae of special enemata.

Conditions for which enemata are given:

(a) To supply fluid to the body. Thirst may be relieved by this means.
(b) For stimulation.
(c) For sedative effects.
(d) In conditions in which fluids, food, or medication are not given by mouth.
(e) To evacuate the bowel.
(f) As a treatment for chronic constipation.

The bowel contents (feces) consists of:

"1. Food residues (a) those portions of food which have escaped absorption and (b) that part of the diet either not digested or incapable of absorption.
"2. The remains of the intestinal and digestive secretions not destroyed or reabsorbed.
"3. Substances excreted into the intestinal tract, notably salts of calcium, iron and other metals.
"4. The bacterial flora of the intestinal tract.
"5. Cellular elements to which may be added, under pathological conditions, blood, pus, mucus, serum and parasites.
"6. Abnormally, enteroliths (intestinal concretions), gall stones and pancreatic calculi." (Hawk and Bergen, "Practical Physiological Chemistry.")

Anatomy.—The organs which are chiefly affected by the enema are the colon, rectum, and anal canal.

"The colon is divided into four parts—ascending, transverse, descending, iliac and sigmoid.

"The ascending colon passes upward from its commencement at the cæcum to the under surface of the right lobe of the liver. It bends abruptly to the left, forming the right colic (hepatic) flexure.

"The transverse colon, the longest and most movable part, passes with a downward convexity from the right hypochondriac region across the abdomen into the left hypochondriac region, where it curves sharply on itself beneath the lower end of the spleen, forming the left colic (splenic) flexure.

"The descending colon passes downward through the left hypochondriac and lumbar regions, where it ends in the iliac portion.

"The iliac colon, situated in the left iliac fossa, is continuous with the descending colon. It begins at the level of the iliac crest and ends in the sigmoid.

"The sigmoid forms a loop. It is continuous with the iliac colon, passes transversely across in front of rectum to right side of pelvis. It then curves on itself and turns to the left side to reach the middle line at the level of the third piece of the sacrum. It bends downward and ends in the rectum."

The rectum is about 12 cm. (4–5 inches) long. It is continuous above with the sigmoid colon and below with the anal canal. "From its origin at the level of the third sacral vertebra, it passes downward, lying in the sacro-coccygeal curve and extends for about 2.5 cm. (almost one inch) in front of, and a little below the tip of the coccyx. It then bends sharply backward into the anal canal. The rectum is lined with mucous membrane which is arranged in longitudinal folds when it is contracted. These folds disappear when the rectum is distended. There are other permanent, transverse, semilunar shaped folds of membrane, 2–4 in number, which are known as Houston's valves. When the intestine is empty, these valves overlap one another."

"The anal canal is from 1 to 1½ inches long. It is surrounded by the internal and external sphincter muscles. Folds of mucous membrane and muscular tissue called rectal columns are placed vertically in the canal. They are separated from each other by furrows known as anal valves. The anal canal is directed down and backward forming an angle with the rectum. The external opening is called the anus." (Gray.)

The rectum is supplied by hemorrhoidal arteries. The veins, when distended, may cause hemorrhoids (piles). This is a condition frequently encountered and necessitates more than ordinary skill in giving an enema.

A nurse must understand the position and structure of the rectum and anal canal in order to be able to insert a rectal tube successfully. Undue force may injure the mucous membrane or wall of the intestine.

Preparation of materials and equipment for giving an enema to an adult.—Articles necessary:

One blanket.
One large sheet.

One draw sheet folded with a piece of rubber sheeting 36 inches square.
Bed pan and cover, toilet paper.
A large tray containing an irrigating can, tubing and clamp.
Pitcher containing two quarts of soapsuds solution (made by dissolving one tablespoon of soap jelly in one quart of water). Temperature of solution, 105 degree F.
An enamel basin, in which two rectal tubes and a glass connecting tube, wrapped in gauze, have been boiled.
Vaseline for lubricating tubes.
Emesis basin for soiled tubes.
A towel.
An irrigating stand.

Note.—If a small enema is to be given, a funnel is substituted for the irrigating can and tubing.

Individual methods of preparation of materials and equipment for giving an enema are employed in each school of nursing but general principles of the procedure underlie all methods.

Opportunity for practice should be provided as soon as possible after the lesson has been taught in the classroom. The student should be carefully supervised the first time she gives the treatment.

Method of procedure.—In this, as in all other treatments, a patient should be told what procedure is to be carried out. Necessary explanation should be made, in order to relieve a patient's anxiety or fear. The equipment should be arranged at the bedside in the manner in which it is going to be used.

In preparation of materials, special attention should be paid to the selecting of rectal tubes, the nurse should observe their general condition, and whether or not the tips are cracked. Boiling the tubes in normal salt solution for three minutes prevents softening (the result of frequent boiling).

Position and draping of the patient.—The patient may lie on either side, with the knees drawn up, or she may be in the dorsal position. It is usually more convenient for the nurse to have the patient turned on the left side.

The lower limbs are draped with a sheet and the patient covered with a blanket. Patients frequently complain of chilliness. Care should therefore be taken to keep them warm. In the case of babies and young children, they should be carefully wrapped in a blanket and stockings worn.

Technic of giving the enema:

1. The height at which the irrigating can is adjusted is usually two feet. This varies according to the degree of rapidity and pressure of the flow desired.
2. The air should be driven out of the tube by permitting the solution to flow for a moment before introducing it into the bowel. The water which has cooled in the tubing is also expelled.
3. The rectal tube, carefully lubricated, is inserted gently just beyond the internal sphincter and the water allowed to enter the bowel.

Note.— "The so-called high enema tube is quite unnecessary for filling the bowel; it simply coils up in the ampula without entering further." (Carman-Miller.)

4. If there is obstruction to the tube, the nurse should try to ascertain the cause. It may be due to
   (a) Increased muscular contractions of the rectum—in which case the warm fluid is allowed to run through the tube as it is being inserted; the heat will relax the muscles.
   (b) Coiling of the rectal tube—if a firm tube has been selected, this will not be likely to occur.
   (c) The rectum may be packed with fecal matter. In this case the nurse should put on

a glove, lubricate the forefinger with vaseline, insert into the bowel and remove the fecal mass.

(d) When it has been ascertained that none of the above complications exist, the condition should be reported to the doctor, as there may be a growth in the rectum.

"The evacuant enema is given rapidly and by sudden distention of the rectum or by direct irritation of the bowel wall, results reflexly in active forward peristalsis, at least of the descending colon, with expulsive contraction of the rectum, and relaxation of the anal sphincter." (Bastedo.)

"In the case of a sensitive colon, the patient may complain of cramps. Massage of the abdomen will help relieve this condition." (Axford.)

Reducing the pressure of the flow, which causes the colon to fill slowly, or shutting off the flow entirely for a few seconds, helps to relieve the pain and enables the patient to continue the treatment. Better results are obtained if the patient retains the enema from three to five minutes. Pressure made against the anus with a folded towel assists in retaining it.

"The capacity of the adult colon depends not only upon its length but also upon the tone of its musculature. The amount required to fill it within the limit of comfort ranges ordinarily from 40 to 60 fl. oz." (Carman-Miller.)

"The colon fills within two to three minutes by gravity. This can all be demonstrated in the x-ray laboratory."

Since practically all hospitals are equipped with x-ray laboratories, it is possible, through the coöperation of the roentgenologist, to include this demonstration in the teaching of enemata.[1]

After the enema has been given, the student should avoid contamination of her hands by unnecessary handling of the soiled rectal tubes. They should be handled and cleansed with paper before being washed.

Observation of the results of the enema.—Observation of the results of the enema should be carefully made. Abnormal characteristics must be watched for. The color, amount and consistency of the feces are noted. Accurate charting of the treatment is done as soon as the procedure is completed.

Test of good nursing work.—It is desirable to have the student develop the habit of self-criticism. The test of her work may be made by:

(a) Observation of therapeutic results, comfort and satisfaction of the patient.

(b) Neatness and finish in appearance of her work.

(c) Economy of time, effort and materials.

(d) Ability to analyze the experience, to organize the nursing principles inherent in the procedure, and to use them in other situations.

Summary.—This procedure affords opportunity for correlation with:

(a) Anatomy—a knowledge of the structure of the colon, rectum, and anal canal is necessary, in order to give the treatment successfully.

(b) Physiology—gives the student an understanding of the reaction of the bowel to mechanical stimulation.

(c) Chemistry—the character of the bowel contents is a result of chemical and mechanical digestion. The student's ability to interpret abnormal characteristics depends on her knowledge of chemical and other

[1] Demonstrations given to student nurses by Dr. W. Homer Axford, Roentgenologist, Jersey City Hospital.

changes which occur in the intestinal tract.

(d) Bacteriology—is applied in the prevention of contamination of the student's hands by soiled rectal tubes; also in the necessity for immediate sterilization of the rectal tube before giving a treatment.

(e) Psychology—is involved in the relation of the student to the patient, in

(a) Skill in carrying out the treatment.

(b) The ability to inspire confidence and the right mental reaction on the part of the patient.

(c) The principles of habit formation are involved in acquiring good technic.

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Coöperation of Librarians

AT the annual meeting of the Nebraska State Association in Omaha, the Public Library had an intensely interesting exhibit made up of attractively displayed books and posters. The booth was almost constantly occupied by nurses who seized the opportunity to make acquaintance with new or unusual books. Reading lists were freely distributed. A striking feature was the distribution of a leaflet, the cover page of which we reproduce, for the librarians wisely chose to play up books which related to Mental Hygiene, a major subject on the program.

FROM COVER PAGE OF OMAHA PUBLIC LIBRARY BULLETIN

It is probable that most public libraries would carry books on nursing subjects if the professional organizations would take the trouble to interest them and to aid in the selection of worth-while books. Librarians are notably coöperative once their attention has been attracted and their interest aroused. When Agnes G. Deans was acting as field secretary for the A. N. A., she visited many libraries and found a startling dearth of literature pertaining to nursing. Since libraries can respond only to expressed needs, it is suggested that a closer relationship might exist between the district associations and the public libraries.

The Alumnae Association

The Open Door of Opportunity

VIRGINIA McCORMICK

"YOU are on the threshold of a new life. Graduation is the open door through which you pass to a greater field of service."

The speaker paused for a moment and looked down at the rows of white-clad nurses in the graduating class before him. Some sat unblinkingly staring ahead; it was evident they were not listening. Some were hearing the speaker, but only with their ears; there was no response written on their faces. About many was a look of intensity and high-keyed awareness of the moment.

It was to these last that the speaker addressed himself. He was president of the hospital board, and always at graduation he talked about the *open door of opportunity*. To be sure he varied his theme, adapting it to some pertinent problem of the day. But always he spoke of the open door and always he was sure of a response from those nurses to whom graduation meant, in reality, the threshold of future service.

But the speaker was not very specific about what lay ahead of the nurse beyond the open door. He was not familiar with nursing procedure and could not tell his hearers of the path to take when the hospital was left behind. He might have saved those keen-eyed, eager young women much perplexity had he been able to conclude by saying, "Beyond the open door of graduation lie a multitude of paths. If you wish, you can go alone, solitary and isolated in your work, out of touch with professional progress, static in your own development.

"If you choose, you can become one of a group that is restless and erratic in work, moving from place to place, taking a case only when the nurse herself wants it, recognizing no obligation or motive power beyond her own wishes.

"Or you can choose the road that leads to constructive service, to the fullest development of your own capabilities, to success in your profession. This road is a busy thoroughfare, travelled by many others doing what you are doing. On this road you become one of the great body of organized nurses throughout the world. You enter it by way of your alumnae association."

Too often the young nurse thinks of her alumnae association as a group of nurses, most of them much more experienced than herself, among whom she feels out of place.

In spite of all the sincere efforts of hospital superintendents to stress the value of organization, and of alumnae associations to explain their function and value to the graduates from hospital schools, the significance of the alumnae association often is not realized by the nurse who is entering her profession.

What Is an Alumnae Association?

1. *The hospital alumnae association* is the basic unit of organized nursing in the United States.

2. *When the nurse becomes an active resident member* of her alumnae association, she becomes automatically a member of her district and state associations, of the American Nurses' Association, and of the International Council of Nurses.

Why an Alumnae Association?

THERE are four distinct reasons for an alumnae association:

1. It benefits the nurse.
2. It benefits the hospital.
3. It benefits the profession.
4. It benefits the public.

The Nurse.—Relatively few individuals can grow and develop to their fullest powers through isolated, unorganized, and unsupervised methods. In nursing this is particularly true. The very function of her profession, her training, and the administration of nursing requires the contact of the nurse with other nurses. The alumnae association is the nurse's link with her alma mater. To it she turns for information, advice, association in friendliness with others having the same interests. Through her alumnae association she can develop her education continuously and participate in the activities of her profession.

The Hospital.—"Helpful coöperation without too much criticism, and no dictation," is the contribution universities desire most fervently from their graduates, according to telegrams and letters read recently at the Cornell Alumni Corporation Convention. The same may be said for hospitals.

Certainly the interest of the alumnae should center in the work of their hospital training school with the view to raising constantly the educational standards, toward further affiliations, toward graduate courses. The interrelationship between the hospital registry and the official registry should be a matter of concern to the alumnae. The function of the hospital in meeting the needs of the community in its health problem should be a subject for study with a view to coördinating the work of all health agencies in a single community program.

The Nursing Profession.—Nursing education and practice in the United States sets a relatively high standard today only because organized nursing has worked for these things vigorously during the past thirty years. Every state has its nurse practice act and states have their accredited schools only because back of these movements has worked the nurse in her state association. And the integral groups of the state association are the district associations which are composed of the alumnae associations.

The Public.—Unlike professions other than those of healing, the nurse thinks, first of all, not of herself or her profession, but of her patient. Whatever is done toward raising standards in nurse education and technic, whatever nursing laws are enacted in the states, reflect immediately on the consumer of nursing—the patient.

When the nurse joins her alumnae association and unites herself with organized nursing, she commits herself to the fullest possible service to the public, not only through her personal ministry to the individual patient, but through active interest in movements to protect and promote community health.

Alumnae Membership

THE American Nurses' Association is inclusive rather than exclusive. Its policy toward active alumnae membership is dictated by the belief that every reputable registered nurse in the United States should be a member of the national organization and that she should be an active participant in the activities of her integral nursing group; *i. e.*, her alumnae association, if she resides in the district of her alma mater; or her district association, if she resides in a district or state other than that in which is situated the school of nursing from

which she was graduated. The active alumna receives her membership in the national association through her alumnae group which is part of the district and state organizations.

Non-resident Membership.—The non-resident member is the nurse who has left the district in which her alumnae association is located, but she retains contact with her alumnae as a non-resident member and pays a nominal fee. She then applies for individual membership in the district where she resides—and through this district membership becomes a member of the State and the American Nurses' Association.

American nurses in foreign countries attached to such units as army or navy nursing or in missionary service customarily are accorded active membership in their alumnae associations. This is true also of nurses in the United States whose duties take them constantly from place to place.

Associate Membership.—Associate membership in an alumnae association is for those who are not eligible for active membership.

Some alumnae associations extend associate membership to those registered nurses who have retired from active nursing. Graduates who are not registered may be accepted as associate members by their respective alumnae associations. No associate member may vote on other than alumnae affairs.

Married nurses should be retained as active members in the American Nurses' Association through their alumnae, district, and state associations. The national board recommends that associate members be only those not eligible for active membership and emphasizes the restricted privileges of associate membership. That entire question is, of course, one for the decision of the individual alumnae association.

Some Alumnae Association Problems

Non-resident Dues.—Non-resident members pay their *national* dues through their district of residence and not through their alumnae associations. Difficulties constantly arise, nonetheless, because some alumnae associations insist upon non-resident dues being the same amount as that paid by resident members who thus obtain also their membership in district, state, and national organizations.

This situation occurs, it seems, only because these alumnae associations fail to recognize the fact that when they ask the same dues from resident and non-resident members, they virtually are asking the latter group to pay the amount of their state and national dues a second time, and they fail to take into account that they can offer the non-resident nurse only membership in her alumnae group with none of the broader contacts in which she can participate wherever she resides.

The result inevitably is a sad one. Either the nurse severs all connection with her alumnae association and her alma mater because she is indignant at the high dues, at the same time retaining her national membership through her district of residence; or she pays only the dues demanded by her alumnae association, forfeiting state and national membership when she fails to pay the dues of the district where she lives; or she gets discouraged with what she considers the injustice of the situation and drops all her professional contacts.

Deficiencies.—Nurses have been refused membership in their alumnae associations by reason of the fact that they entered training without the

required educational credits, this refusal being made in spite of the fact that the nurse has made up these deficiencies and has been graduated from her school. Such an attitude is, of course, entirely unjust and is contrary to the inclusive policy of the national organization.

Reinstatement of Delinquent Members.—All but eight state associations now have written into their by-laws that the delinquent members of their constituent associations may be reinstated by paying their dues for the current year, instead of by compulsory payment of all arrears. This policy applies equally to alumnae associations and is urged by the national organization as a step toward increasing the number of members in organized nursing groups.

Transfers.—When a nurse changes her place of residence, her membership in the American Nurses' Association is transferred from the district or state organization in which she formally worked to the new district or state where she is taking up her residence. A unified system of transfer cards throughout the country is being worked upon, but has yet to be evolved whereby the nurse can be transferred without loss of time or superfluity of detail. But the system of transfers is operating successfully in many states, and it is only a matter of time until transferring the membership of a nurse to any part of the country becomes a simple gesture and an easy routine.

One of the adjustments which sometimes is needed is protection whereby the transferred nurse shall not have to duplicate the payment of her dues. There are district and state associations which require the payment of the annual current dues by the newly transferred nurse in spite of the fact that she already has paid those dues in the district or state where she formerly resided.

District and state associations often are very slow in attending to the matter of transfers for the members who are moving to other cities. The result is either that the nurse retains her membership in her former association and, after waiting and worrying for a time, forfeits her national contact, or she breaks with the association of her alma mater entirely and may or may not continue her national membership by allying herself with her new district.

Prompt coöperation on the part of the district and state associations in attending to transfers is of very great help to the nurse who is going elsewhere to work. Until the proposed uniform transfer card is put into operation, continued promptness, patience, and coöperation are absolute requisites on the part of the nurse, and the district and state groups.

The Open Door

THE door of opportunity stands open to every nurse whether she be the youngest graduate or the veteran with many years of good works behind her. We believe the fullest opportunities and the richest achievements are for those who unite with others of their profession on the road that leads to the goal of all nursing—to bring intelligent, highly skilled, tender ministry to every person in need of care.

The nurse working alone cannot reach this objective. The national organization cannot do it. But the nurse working in and through her immediate group which has been her door opening into opportunity, and the American Nurses' Association working through the nurse, can continue along the path of professional progress until adequate nursing

education and practice and an equalized distribution of service turn from objectives to reality.

We have described the structure of the alumnae association. But like the structure of the human body, it is a useless bulk unless the spark of life be there. Like the human body the alumnae association will develop in usefulness and in the fulfillment of its powers only when the mind directs, the will controls, and the spirit gives life.

The Spirit of the Alumnae[1] has been beautifully described by Major Julia C. Stimson who concludes by saying:

> We are each of us concerned about the profession of nursing. We want to see its standards higher, its progress greater, its position more assured, its leaders more powerful. Our national organizations are doing everything in their power to accomplish these ends. But since the basis of these groups is the alumnae association, and the basis of the alumnae association is the individual nurse, where should the attack be aimed—for more strength, more character, more personality, more spiritual power—except upon ourselves, the individual units of our alumnae associations?
>
> We cannot expect great things of our associations unless we expect great things of ourselves. And to expect and secure great things of ourselves we must expect great things of God and be aware of our relation to Him. . . . Moral dynamos—why are we not all moral dynamos, full of energy, making truth live, spreading goodness in new forms? And this means an awareness of God. Such a consciousness of connection with the source of power cannot but make personalities more effective, and make us think more of our individual responsibilities toward ourselves, our associations, our school, the younger nurses as a whole, and the individual ones with whom we may come in close contact. The spirit of the Alumnae Association should be the spirit referred to in the text, "Let this mind be in you which was also in Christ Jesus."

[1] Reprints procurable at Headquarters, American Nurses' Association, 370 Seventh Avenue, New York City.

Coöperation in Georgia

AT the annual meeting of the State Nurses' Association, in November, it was announced that, through the efforts of the Executive Secretary, Jane Van De Vrede, the State Medical Association had increased the membership of its hospital committee to five and had instructed the committee to take the initiative in forming a hospital association for Georgia. The advisory committee of the State Nurses' Association was authorized to meet with the hospital committee of the State Medical Association to further the project.

Georgia nurses have been studying the problem of supply and demand in nursing and have found that two-fifths of the nurses already graduated reside, with one-fourth the population of the state, in sixteen of the larger towns. This is undoubtedly due to lack of hospital facilities in other places. An editorial in the *Journal of the Medical Association of Georgia* for November makes a strong plea for more community hospitals, from which we quote:

"There is no more reason for expecting physicians to provide hospital facilities for communities than there is for requiring lawyers to furnish the court houses for the trial of all civil suits. The physicians of every community gladly do all charity work required. Since this is true, may they not reasonably expect the community itself to furnish the place and facilities for doing this work?"

The State Nurses' Association in yet another series of resolutions, endorsed the movement to provide care for the tuberculous in general hospitals, and thus to increase the opportunities for teaching the care of tuberculosis to student nurses.

A System of Honors and Credits

RACHEL McCONNELL, R.N.

THE system of honors and credits in use at the Hartford Hospital Training School for Nurses was instituted in 1925, because it was noted that students seemed to work and study because they were obliged to and, apparently, not because they wanted to.

Beginning with the fall class of that year, a notice was put on the bulletin board announcing that a plan for class distinction of students was going to be put into effect and the ruling was to be as follows:

All students who had been in the school two years and who had passed all examinations in the theory and practice of nursing, in that year, were to be given a ¼-inch blue band for their caps and were to be known as Senior students. All students who had been in the school one full year and who had passed all examinations in the theory and practice of nursing were to be given long bibs and were to be known as Intermediate students. (When students enter the school, the bibs button on the shoulders.) All Preliminary students who had completed four months in the school and who had passed all examinations in the theory and practice of nursing were to be given caps and were to be known as Juniors.

The effect of promotion showed a decided improvement in studies.

It was therefore decided to adopt a merit system the following year in order to give students who were studious, industrious and faithful, proper recognition, and so the following method was adopted:

To create an honor roll and to give a Hartford Hospital Training School pennant and insignia in school colors to those students who won them.

Points to be won for H. H. T. S. pennant	140
Points to be won for H. H. T. S. insignia	125

Method of obtaining total number of points:

Yearly average in theory and practice of nursing, for pennant	90
Yearly average in theory and practice of nursing, for insignia	85

The remainder of the points to be made up from the following:

Original idea for the good of the school	15
Outstanding leadership, to be determined by each class	10
A successful recreational achievement	10
Outstanding work in emergencies and efficient work	10
Full attendance on duty for year	10
Punctuality in attendance to all classes	5
Observation of all residence rules	5
Outstanding neatness in rooms, monthly	1
Attendance at church for two consecutive Sundays, record to be handed in by a chosen member of each class	1
For every new student	5
Points to be lost if reprimanded for personal appearance at uniform inspection	1

At the close of the year's work there was some improvement shown, but no student won the pennant and only three won the insignia. Marks in studies showed some improvement, but students did not realize the importance of other accomplishments. In order to still further instill a spirit of enthusiasm into the school, the two students who obtained the highest number of merits were given a free trip to Atlantic City to attend the nurses' biennial convention of the three national organizations which was held in May, 1926, and were obliged to give a report of the convention to the student body at the monthly student conference.

At the commencement of the next school year considerable effort to have a high standing in the school was

evidenced, students began to take more interest in their studies and very frequently one heard: "What clubs are you planning to join?" or "What recreational achievement are you trying for this year?" Students had begun to take our merit system and honor roll more seriously, with the result that sixteen won the insignia and two students won the pennant that year. During the same year the nursing staff and student body each earned $2 towards a $500 scholarship which was presented to the member of the graduating class who had attained the highest average in the theory and practice of nursing for three years, and so fresh enthusiasm was gained in 1926. Last year we saw many signs of growth, more students put earnest effort into their work, with the result that eighteen students won the insignia and five students won the pennant. The two students who held the highest number of merits were given a free trip to the biennial convention, in Louisville, Kentucky, in June, and the student who had attained the highest average in the theory and practice of nursing for three years, was given a $500 scholarship, through the generosity of the medical and surgical staffs of the Hospital. The two scholarships given are to be used for college work in teaching or administration, and the winners are at present on the staff of the nursing department, where they are gaining practical knowledge, prior to entering Columbia University for such courses.

The merit system has done much towards creating a healthy enthusiasm in the school, developing leaders, and making students strive for a goal much higher than a diploma, at the end of their three years' course. Several of our students are planning to take advanced work in teaching, administration and public health after graduation.

In 1925 we organized a glee club and since that time we have given two concerts each year and have broadcast several times at the local broadcasting station.

In 1926 a dramatic club was organized and two successful productions have been staged since that time.

We have also a basketball team and Girl Scout troop. All of these clubs were thought of by students who were anxious to obtain points in leadership.

Each club was formed independently, had its own rules, officers and bank account, until last year, when the officers from all classes met to discuss the advisability of having one large organization. It was decided at that time to amalgamate all clubs and to form an Activities Association for all members of the school. There were students who did not belong to any club, but who wanted to feel that they were assisting in school activities, and there were those who wanted to derive any benefits they could from the school without taking an interest in anything. The student body voted to pay $5 for the first year's dues, and a council was afterwards formed as follows: President, Activities Association, who was also President of Senior Class; First Vice President, who was also President of Intermediate Class; Second Vice President, who was also President of Junior Class; Secretary; Treasurer; a representative from the Senior Class and also one each from the Intermediate Class, the Junior Class, the Glee Club, the Dramatic Club, the Basketball Team, the Girl Scout Troop, making a total of twelve students on the Council.

All bank accounts were transferred to the treasury of the Activities Association and debts were paid from

the one account; it is worthy of note that at the end of the year there was over $400 in the bank after all debts had been paid (debts consisting of the salary of the professional glee-club conductor and the dramatic coach, programs and tickets for concerts, decorations, stage equipment, and all other incidentals pertaining to each club). The object of the club is to grow in usefulness to the school, by assisting in all matters pertaining to the life of the student, both in educational advancement and in recreation.

Nursing in a Rural Community in Missouri

MARY E. STEBBINS, R.N.

(Continued from the January *Journal*)

Outlook for Nursing Service in Rural Missouri Communities

HOW do all these conditions affect the problem of nursing in such districts where, in addition to other problems, we find, the doctors are few and widely scattered (one doctor serves practically an entire county and the boundary areas of the surrounding counties); few, if any, skilled nurses; hospital facilities are limited or entirely lacking; money is so scarce that hospitalization is not to be thought of except as a last resort in the most serious cases; little, if any, sentiment has been built up which would make professional nursing care a desirable and sought-after service? Tradition, habit and custom have established a system of dependence upon each other and true neighborly, though unskilled, kindness, for all or almost all nursing care that is given.

Never doubt the sincerity of such neighborly efforts and all that that implies of nights of lost sleep and real hardship after days of arduous toil in the home or on the farm, for the men help too. They *want* to help, these neighbors. They realize and deplore their lack of knowledge and skill but as matters now stand they are not only "an ever-present help in trouble," but practically the only help. If their efforts are sometimes bungling, ours is the fault, not theirs. Facts revealed in "Nurses, Patients and Pocketbooks" have clearly pointed out where the professional nurses are. By elimination *we know where they are not* and that we have left our more or less isolated families to take care of themselves and each other as best they could. We have even presumed, at times, to criticize their methods and practices.

How long will it take the rural communities to realize that even the truest neighborly kindness, unskilled in nursing, does not take the place of experienced supervision or of even short intervals of scientific care? How long will it take us to make real nursing care possible and available for them? How shall we meet their standards of unselfishness, self-sacrifice and dogged persistence? What type of nursing service will best serve the needs of these people? How much can they afford to pay for? How much do they really need? How often will a full-time nurse be really necessary? How can any nursing service be provided?

No accurate answers can be given

to these questions now, but it is safe to surmise that a self-reliant people, accustomed to getting along well on much less than many of us would consider quite meager, will not require, or desire more than a minimum of nursing service for a long time to come; and that full-time, twenty-four-hour-a-day nursing service for one patient is rarely a necessity in city or country, regardless of economic conditions. A nurse going into a rural district to build a practice with the intention of giving full-time, special, "private duty" care would probably find herself idle most of the time; at best cases would be "few and far between" and of short duration.

The type of service that would seem to hold some promise of meeting the obvious demand would be one on a paid, hourly or visiting-nurse basis, whereby numbers of families could be served simultaneously by one nurse. It has been estimated that one visiting nurse for 2,000 or 3,000 people is a workable proportion for a city population but that a nurse in the country can serve 10,000 people. Sounds a bit odd, doesn't it, in the face of all the difficulties of distance and poor transportation in the country? Based on this proportion of nurses to population, one visiting nurse could serve an entire rural county of 7,000 or 8,000 people. Considering the 407 or 655 square miles involved, condition of roads, etc., physical difficulties might be encountered.

With such a visiting nurse service, whether an individual venture or under the auspices of an organization, the charge could be sufficiently reasonable so that people would want to avail themselves of it—when it has proved itself; thus the unhappy, uncomfortable sick would have the torment of their pain and their sickness eased, the burden of responsibility would be lifted from the family, who could "carry on" the nursing care successfully under the directions of the nurse and between her visits; and the nurse could, in due time and in all probability, build up a lucrative clientele without even the shadow of financial stress casting itself upon those served.

Slow progress should be expected. It is reasonable to suppose that individual and community interest in professional bedside nursing care would develop very gradually. Such a venture would require financial and moral support for some time, possibly for years.

A rural visiting nursing service involves much expense, relatively more than a city service of the same type. A nurse or an organization contemplating such a service would need courage and determination to plan for furnishing support for an indefinite period.

Organized volunteer health agencies, national, state and local, have been and are engaged in making demonstrations of health services of various types, over short periods, as by an itinerant nurse service, notably the American Red Cross and the Tuberculosis Association, or over longer periods, as the five-year demonstration in Mansfield, Ohio, and the various ones developed by the Commonwealth Fund. Some of these cover five-year periods. All have been for the definite purpose of showing how much can be done and why it is worth while to arouse the group to self-conscious participation to the end that permanent local health and nursing services may be established for individual and group benefit. It is gratifying to note that the attention of some such organizations is being directed toward bedside nursing care for rural people. Such services would, in time, tend to

relieve some of the congestion of nurses in the cities and provide an attractive field for service.

The Nurse for a Rural Missouri Community

WHAT sort of a person could meet the demands of such a rural nursing service? What qualifications should she have? What could she expect the community to offer in diversion, recreation, living conditions, those things essential to comfort and, to the satisfaction of the normal human desires? How much would she be willing to do without? How could she keep herself normal physically, spiritually, mentally? How keep herself professionally alert without daily professional contacts?

Health she would need, in its broadest interpretation, physical ability, emotional balance, mental poise. It is unwise and unfair for any individual, personally below par, to endeavor to build up in others what she herself has not. Courage she would need; honest thinking, "frankness, vision, loyalty to a clearly recognized objective"—"better lives for all the people."

In addition to being well equipped to give bedside care, she would need many other abilities. She should have as all-important, a true rural-mindedness. This is extremely difficult of attainment unless a person has actually lived among rural people at least some part of her life. Casual contacts and abstract study do not create it. A real study of rural sociology helps. A combination of the two would be ideal. A surface veneer will never survive in the face of the evaluation to which she will be subjected in the minds of rural people. The superficial has no place in their lives. They would tolerate her for a time, if necessary, but in the end she would go down to defeat, unless fundamentally she is one *of* them, finds their problems her problems, their griefs her griefs, their happinesses her happiness. It would have to be a case of "ours" always, not yours there, mine here, but a case of living and serving with, not for, them and for a long period.

A diversified educational background both in professional and lay matters would be of untold value. When one has no one else to whom to refer, only one's self on whom to depend in all sorts of situations, such a background would be a comfortingly solid foundation on which to stand.

A nurse in a rural area would appreciate a public health education and experience. It is to be expected that she would have all sorts of unusual affairs presented to her for solution, and would find invaluable a knowledge of how to proceed to unravel the tangles in a life or a home or a family, where to get the right kind of care for a crippled child or corrective treatment for those needing it, where to get advice when the school board comes for it, or when the truancy problems are referred to her, how to proceed in the hundred-and-one other situations which are constantly recurring which sickness in the home reveals and emphasizes. Nursing does not confine itself to the bedside care of the sick. It includes so much more and it can be as well done as the background of preparation permits.

Nursing everywhere should include the teaching of health practices and the promotion of right attitudes toward health, the word health being used in its true sense of physical, mental, spiritual and emotional stability. Such health encouragement requires knowledge and experience of a special type, and an everlasting enthusiasm built on a never-wavering faith that this four-fold health is possible of

attainment in vast numbers of cases far beyond what is generally conceded.

The importance of bedside nursing is not to be minimized. That is one of the crying needs today in the open country. The pitifully prolonged cases of illness, the untold suffering and discomfort experienced, the unbelievable sacrifices on the part of the loving care-takers, are beyond description and present a situation demanding amelioration. This bedside nursing furnishes one of the big opportunities to do health teaching in which we are so much interested, and to do it most effectually. It is questionable whether this opportunity is being utilized to its maximum degree anywhere.

Large numbers of nurses are giving excellent care to the sick and hurt, have brought them successfully to a safe convalescence and have exerted little or no influence on their clientele in the matter of building up a health consciousness for themselves, their families, and their friends.

Tolerance our rural nurse must have, far beyond the usual demand for tolerance in every-day life, a generosity of thinking that will let her see the other's point of view always, that will permit a balancing of judgment from all angles, but that will be so steadfast in its ultimate purpose that she will never be deflected from the main path. Patience she will need in vast quantities, persistency and determination in the face of slow changes and little visible improvement in methods of living, and a conviction that worthwhile changes never come about in a hurry, that "success and achievement come as a result of *continuity* of effort."

A nurse in a rural field isolated from professional contacts should certainly take time to read, to keep herself informed in the newer discoveries in professional medicine and nursing for she cannot "go forward, lacking current professional information" and "scientific, progressive occupation needs almost constant refreshing," as Miss Pfefferkorn tells us. She will need to read for general information, also, that she may keep fresh for her people and by the mere force of her habits of enlarging her own outlook, she will unconsciously encourage others to do the same. She will need to be acquainted with the sources of supply of health materials of all sorts. She should be prepared to address all kinds of meetings when asked to do so and not to feel that she cannot, because no library is at hand. The big task confronting any nurse, anywhere, is to teach health and every opportunity should be eagerly welcomed whether it is over the rail fence, at the bedside or in the town hall.

She would do well to hobnob with the editor of the county paper which, it is safe to assume, is read in every home in the county and clipped by neighboring editors. Without violating professional confidences or doing any personal or non-professional advertising, much health information can be gotten to the people in a simple, readable, attractive form.

Any nurse, anywhere, in any type of service, will find her task made easier, her problems more easily solved, her path made smoother, if she has the good will of the doctors in the territory she is endeavoring to serve. A close contact with the county medical society, when there is one, will be a distinct advantage. Several Missouri counties have no medical associations. There it would be wise to meet the doctors personally, to be acquainted with them as human beings and a part of the community, as well as in a professional capacity. There are so few in some of our rural counties

that such contacts would involve little time or travel.

The nurse would, if wise, foster and utilize all agencies interested in health, whether official or voluntary, professional or non-professional. She would do well to remember that records are invaluable, if prosaic, and that their chief value to herself lies in a measure of her own accomplishments.

Comfortable living conditions are a requisite for normal life. If such conditions are not immediately available, they can be developed in much the same spirit that other pioneers have hewn their homes out of the wilderness; patience, determination and the will to survive in fitting fashion, can build a home in one room, a cabin or a palace.

Little of recreational diversion can be anticipated. One of the deplorable and hampering conditions in rural homes and communities is the almost total absence of any kind of recreational facilities or a recognition of their need. The starvation resulting from this lack of play is reflected in the tragedies of life which come into too many of the homes. But a nurse should know how to play, with or without special equipment—with individuals or groups, in the home or at a picnic or church supper. When song and play are in her soul, she can develop song and play in other souls, even if she "can't carry a tune" and her "whistle is a little flat."

If she is a wise woman, and of course she is, she will re-create herself at intervals by taking a little vacation trip, go out of her regular territory for the change of scene. She will also make it a point to attend professional meetings for the informational and inspirational opportunities they offer her; she will in all ways consciously endeavor to keep herself at her best, and to make that best better for the people with whom she serves. The person with her nose constantly to the grindstone inevitably becomes overconscious of the nose.

Summary.—So our nurse in a rural area should be rural-minded, should have a pioneering spirit, the fundamentals of a profession, defined by Miss Clayton as the "ability to assume individual responsibility and having altruistic motives," she should have a love of the people "that passeth understanding," she should be ready to "serve all patients in accordance with their needs (interpreted in a liberal sense) and to be reasonably happy in the growth that comes with thoughtful doing," she should be "a good mixer without getting mixed up herself," and finally she should be an R.N., "rural nurse and real neighbor."

Such a person, backed by a determined organized health agency or group of agencies, with financial resources, could demonstrate a rural bedside nursing service on the hourly or visiting nurse plan for pay, which would include health education as a basic element, and which probably could, if desirable, be more and more taken over by the nurse as the value of the service is proven to the point of being self-supporting. Such a service would be of inestimable value to the large numbers of people served and could provide an example of happy, useful, contented, constructive rural living and serving which should prove an incentive for the development of other similar services.

Grading Committee Studies Small Hospitals

MAY AYRES BURGESS, PH.D.

ACTUAL grading will soon be under way. People are asking "What will be the attitude of the Grading Committee towards the small hospital?" Some are saying "No small hospital ought ever to run a school of nursing, because its students cannot possibly secure the clinical experience which is essential to a nursing education." Others say "But it is only in a small hospital that the student is apt to get that intimate contact with the patient which means that she learns to *nurse* patients instead of merely waiting on them. It is only in the small hospital that the superintendent of nurses has time to be interested in the patients as human beings, and it is the attitude of the superintendent of nurses which determines the attitude of the graduates from her school."

The Committee is gathering many bits of testimony from different sides of this many-sided discussion. Two facts are of especial significance. The first is that the amount of clinical material which a hospital has to offer its students does not necessarily bear any very close relation to the theoretical size of that hospital. The second fact is that although hospitals are repeatedly asked certain simple questions as to the numbers of patients they usually care for and the amount and variety of clinical material they are able to offer their students, many superintendents of nurses are unable to give accurate answers to such questions. This may be because their records are so kept that they cannot readily be analyzed, but it may also be because the hospital has never been accustomed to computing measures, as, for example, the "daily average patients," according to generally accepted methods.

Illustrations of these two facts were found in the experience of the American Nurses' Association when last year it was gathering the data from which it later prepared its "List of Schools of Nursing Accredited by the State Board of Nurse Examiners." Among other questions the American Nurses' Association asked: "What was the number of hospital beds December 31, 1927?" and "What was the daily average number of patients between January 1 and December 31, 1927?" The answers were illuminating.

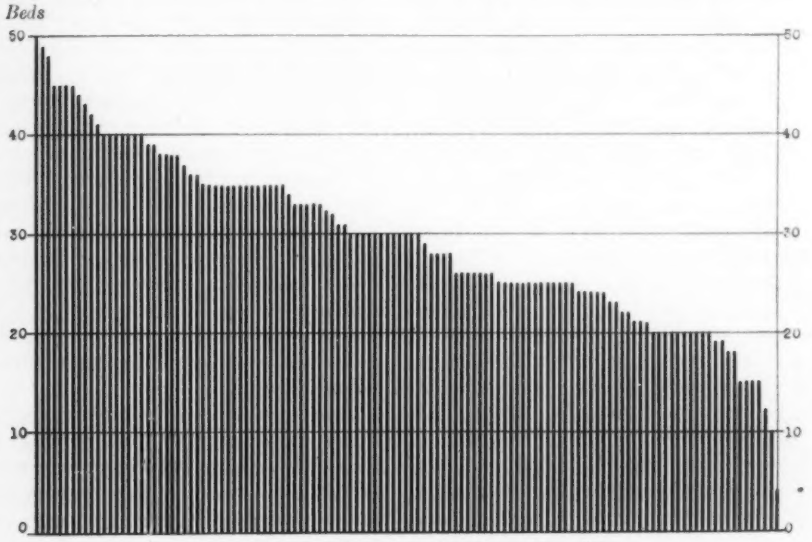
There were, for example, twenty-five hospitals with schools of nursing for which full data were given, all of which claimed to have exactly twenty-five beds. In theory these schools, being of the same size, would have presumably the same numbers of patients and offer practically the same educational opportunities to the students for whom they were responsible. In fact, however, if the returns signed by the superintendents of nurses are to be taken at their face value, these twenty-five hospitals run all the way from one which has a daily average of twenty-one patients and a school of ten student nurses, to one which has a daily average of one patient and a school of six student nurses. For the entire group, the average hospital reported a daily average of fourteen patients and eight students.

It seems probable that these average figures are somewhere nearly correct and that the term "a twenty-five bed hospital" does not by any means mean that student nurses in that hospital will ordinarily have as many as twenty-five patients under observation. It more probably means that at any given time there will be eight

students in the school and about fourteen patients, in caring for whom they are learning the fundamental nursing procedures.

How accurate, however, are the individual entries in such a table? Is it true, as the lower part of the table from which these data were taken now reads, that one hospital has " a daily average of eight patients and ten students," another "a daily average of seven patients with six students," another "five patients with four students," another "two patients with six students," another "one patient with six students"? In all of these cases, is the superintendent of nurses merely making a mistake in the way she figures her daily average or is it true that there are some "twenty-five bed hospitals" which have fewer than ten patients each and yet are trying to conduct schools?

Much the same sort of questions are raised by another group in the same series of reports which the American Nurses' Association courteously puts at the disposal of the Grading Committee for analyses such as these. In this group there were 121 hospitals with schools of nursing, each of which claimed to have exactly fifty beds. At the head of the list is one hospital reporting "a daily average of fifty patients and a school enrollment of thirty-five students." At the bottom of the list are, one hospital "with twelve patients and fifteen students," one "with ten patients and twenty students," one "with four patients and twenty students." The diagram accompanying this article shows the reported daily average patients for each one of these 121 hospitals. For the entire group the average for one hospital is thirty patients and eighteen students.



"WHAT DOES A FIFTY-BED HOSPITAL MEAN?"

Average daily patients reported by 121 hospital schools of nursing, all of which are listed by the American Nurses' Association as having exactly fifty beds each

There are probably some individual inaccuracies in this diagram. It may

be that the superintendent of nurses who reported a daily average of fifty patients for a fifty-bed hospital, and the other who reported a daily average of four patients for a fifty-bed hospital, was, in each case, making a mistake in her method of computing the daily average; but it seems probable that, except for minor inaccuracies, the picture as shown in the diagram is approximately truthful. The story the diagram tells is that to say that "a hospital has fifty beds" gives no clear indication as to how many patients that hospital ordinarily cares for. Students in one of these hospitals may be getting twice as much clinical experience as students in another, although both claim to be "fifty-bed hospitals."

It becomes so important to know how much and what types of clinical material any school of nursing is able to offer its students, that it is unfortunate to be obliged to look upon all such statements from superintendents of nurses with a somewhat questioning eye. In the American Nurses' Association study, superintendents of nurses were asked to indicate the number of months' training students receive as preliminary students and in the medical, surgical, obstetric, pediatric, tuberculosis, communicable, psychiatric, operating-room, and diet kitchen services. These figures are important, not only for national organizations seeking to study the opportunities for student nurses, or seeking to analyze the nursing needs of patients, but for the guidance of the superintendent of nurses herself. It would seem essential for any superintendent of nurses, who is conscientiously attempting to secure for her students a well-rounded clinical experience, to know the amount of each of these different types of experience available through her hospital. As a matter of fact, however, it is clear that there are many hundreds of hospital training schools in this country where, without an unreasonable amount of labor, it is not possible for the superintendent of nurses to tell how many different kinds of patients have been in her hospital during the year, nor how much actual nursing experience each student has had with cases of each type.

In the Accredited List, as finally published by the American Nurses' Association, it will be noted that there are many blank spaces left to indicate that answers to certain questions were not available. Sometimes these have been omitted because the superintendent herself has left the answer blank. In other cases those who compiled the report were so sure that the answers as given could not be accurate and would reflect unfortunately upon the reputation of the school if published as given, that they took the responsibility of omitting them from the printed list.

It should be possible, however, for every superintendent of nurses to answer certain simple questions, such as "What is your average number of daily patients?" knowing that she is using a sound method and that her answer as given will mean exactly the same as the answer of all other up-to-date and well-informed superintendents of nurses. The following paragraphs give a simple method of computing this figure:

To Find the "Daily Average Bed Patients"

THE word "average" as used here means "If all your work for the year could have been spread out evenly, so that each day you would have had just as many patients as every other day, but no more, how many patients would you have had

to care for each day?" The average is not, of course, an absolutely true picture for any hospital, but it is probably more nearly true than any other single figure we can get. It is especially useful when many different hospitals of different kinds must be compared.

In order to compare the relative sizes of hospitals, superintendents are frequently asked how many "daily average bed patients" they care for. The figure for "daily average bed patients" is an attempt to answer the question: "On the average, how many bed patients receive care each day in your hospital?" It is computed in terms of "days of bed-patient care," in which the unit is one bed patient receiving care for one day.

For example:

1 patient in bed for 1 day=1 day of bed-patient care.
1 patient in bed for 3 days=3 days of bed-patient care.
3 patients in bed for 2 days=6 days of bed-patient care.

The method for computing the "daily average bed patients" which is approved by Dr. E. H. Lewinski-Corwin, Director of the Hospital Information and Service Bureau of the United Hospital Fund, is as follows:

1. Find how many days of bed-patient care the hospital gives each year. This is found by taking a daily census, and adding each day's totals. (For these computations stillbirths are ignored, newborn babies are counted as new patients, and bassinets are counted as beds.)

   The census of bed patients receiving care for each day begins at midnight, and lasts until the next midnight. The total patient census for that day equals the number of bed patients in the hospital at midnight plus new births or admissions minus deaths or discharges. If a patient comes in during the day but is discharged or dies before the end of that day, it should be remembered that he has received one day's care, and an extra count should be added to the total care reported for that day.

   For example: Suppose that there are forty patients in the hospital at midnight. Before the next midnight there are two births and three new admissions; one patient died and one was discharged. One patient was both admitted and discharged during that day. The census for that day would be figured as follows:

Bed patients—receiving care beginning of day	40	
Plus births during day	2	
Plus admissions during day	3	
	—	45
Minus deaths	1	
Minus discharges	1	2
Bed patients receiving care at end of day		43
Plus one day of care for a patient included above in both the admission and the discharge figures above		1
Total for daily census count of bed-patient care		44

   This method of computing the daily census is the one recommended by the American Hospital Association in its Bulletin Number 42 "Standardized and Comparable Hospital Statistics and Your Per-capita-diem Cost Figure." It is conveniently computed by separate wards, and the totals for all the wards added to make the day's total for the hospital.

2. The total days of bed-patient care for the year are found by adding all these daily census figures together.

As: January	1	44
	2	46
	3	40
	4	33
	5	39
	6	40
	7	42
	etc.	etc.
December	30	48
	31	47

Total for year, 17,155 days of bed-patient care.

3. The "average daily patients" equals the total days of bed-patient care divided by 365. In the illustration above, if 17,155 days of bed-patient care were given during the year, the daily average would be 17,155 divided by 365, or 47 patients as a daily average.

4. Hospitals are frequently asked to state their "percentage of occupancy." This means, on the average what per cent of all your beds are occupied each day? An easy method of finding this figure is to divide the "daily average patients" as figured in the illustrations given here by the total number of beds in the hospital.

   For example, if the hospital has a daily average of 47 patients, and actually has 50 beds which could have been occupied, its percentage of occupancy is 47 divided by 50; or 94 per cent. This is of course an unusually high percentage.

   Another method for computing this figure is to divide the total days of bed-patient care by 365 times the total number of beds. In the illustration given here this would mean dividing 17,155 by 365 times 50; or dividing 17,155 by 18,250. This again gives 94 per cent as the answer. Either method may therefore be used.

This article, and the diagram which accompanies it, are printed here in order to illustrate the type of situation which the Grading Committee must take into consideration in considering standards for schools of nursing. Merely to say "a twenty-five" and a "fifty-bed" hospital gives very little indication as to what that hospital can offer to the student, and it is evident that the Grading Committee must gather much more detailed information than merely the number of beds.

Undoubtedly one of the grading questions should be: "Please state your daily average number of bed patients, computed on the basis of the daily census recommended by the American Hospital Association." It will, therefore, help in later grading studies if superintendents of nurses will acquaint themselves with this simple method and learn how to use it. Otherwise the Grading Committee may be obliged to accept figures, given in good faith by the superintendent of nurses, but which, because wrongly computed, might lower the grade which her school would have secured had she known how to figure the daily average correctly.

The matter of securing accurate records to show the different types of patients, and therefore the different types of clinical service which students have been able to secure, is a much more difficult thing. It would seem probable that before the Grading Committee finally finishes its work it will be asking hospitals to keep their records in such form that they will be able to give information of this type. At the present time, however, there are probably many hospitals which will not be able to answer these questions. Ultimately it would be an advantage for the rating of any hospital if it were able readily to get this

information for the Grading Committee, but considerably more important than that is the fact that any superintendent of nurses who wishes to be sure that her students are being given a thorough grounding in bedside nursing must be very anxious, quite apart from any prospective demands from the Grading Committee, to keep such careful records for herself. Unless she knows how many patients of each type each student has been able to care for, how can she know whether the student has had the experience which she must have if she is to be a good bedside nurse when she is graduated?

One further suggestion is raised by the diagram which accompanies this article. If hospitals of equal numbers of beds vary so widely as to the numbers of patients they actually care for, should this fact have any bearing upon whether their graduates are admitted to the various nursing organizations, registries, etc.? Is the time coming when nurses will attempt to define much more definitely and clearly than has hitherto been the case what sort of hospital educational background they shall make a minimum requirement before they will admit graduates from nursing schools to membership in the professional nursing organizations?

Discovery of Paroidin

MARGUERITE B. BREEN

This article is published for its intrinsic interest. It is also a reminder to nurses that it will be difficult to support the claim of nursing to the coveted status of a profession until nurses more generally adopt the scientific method of experimentation, i. e., experiments, recording of results, checking up of findings, and the publication of conclusions, in order that they may be further tested by practitioners of the art of nursing.

OUT of a crude basement laboratory from an obscure country physician who overcame many obstacles has come, within recent months, a great contribution to medical science and to humanity. The physician is Dr. Adolph Hanson, struggling scientist of Faribault, Minnesota, and his discovery is the extraction of the active hormone of the parathyroid glands of cattle and a resulting remedy "Paroidin," which will make possible the cure of tetany and relief in many other maladies.

Announcement of the official acceptance of this new remedy is made in a recent number of the *Journal of the American Medical Association.* To Dr. Hanson this recognition spells victory after years of plodding research and endless experiments, with all the failures and discouragements that invariably accompany this type of work.

A year earlier, this earnest young scientist had stood before the doctors of Minnesota assembled at their annual meeting and announced his discovery. The announcement was received with incredulity while charges of "over-enthusiasm," and "too-hasty conclusions" were heard on all sides.

Undaunted by this disheartening reception of what he believed to be a discovery of vital importance to medical science, Dr. Hanson sought the interest of one of the leading commercial drug companies of the country with the result that he was invited to spend some time in its research

department developing the preparation which has appeared under the name of "Paroidin."

And now, finally, as a climax to his years of effort has come official recognition from both state and national medical associations. The Council on Pharmacy and Chemistry of the American Medical Association, in announcing acceptance of the new remedy, says in the July (1928) *Journal:* "Paroidin is of pronounced and definite value in the treatment of tetany and has the property of increasing the calcium content of the blood serum." Dr. Hanson was awarded the prize of $250 for the best work presented before the Minnesota Society of Internal Medicine during 1927.

The new extract is believed to equal insulin in the possibilities of its benefits to humanity. Its outstanding use is in the cure of tetany or muscular convulsions, which may develop following goitre operations as a result of the removal of or injury to the parathyroid glands. It is also thought that the new remedy will be helpful in the treatment of many other bodily disorders because it tends to restore the general metabolism. Longer and more general use, it is believed, will prove its value in the treatment of St. Vitus dance, ulcers of the stomach, inflammation of the bladder and joints, and delayed healing of wounds.

The story of this discovery is the story of plodding, patient effort and a courageous fight against odds. Lack of funds, of proper equipment, and the disinterest of fellow physicians failed to daunt the determined young physician. Working in a crude laboratory, arranged in the basement of his Faribault home, Dr. Hanson has during the last six years utilized every moment that could be wrested from the demands of a country physician's practice. Unlike the hero of Sinclair Lewis' novel, "Arrowsmith," he did not think it necessary to desert his family and bury himself in an isolated spot in the woods in order to do research work. His home was maintained and his wife and four children were supported by his regular practice while experiments had to be pushed into the hours when most people sleep.

Hundreds of ox glands from freshly butchered animals were procured from one of Minnesota's large packing plants. Tetany was developed in more than 300 dogs through the removal of the parathyroids. Substances extracted from the glands of the oxen were then administered to these dogs to test the effect on the disease. Experiment after experiment failed. Made of stern stuff, repeated failures only served to spur on the doctor to greater effort. Finally came the triumphant day when perseverance was rewarded, and Dr. Hanson was convinced that he had at last extracted the active principal from the parathyroids and had found the cure for tetany. This was accomplished by boiling the tissue of the ox glands in hydrochloric acid.

This discovery demonstrates that confidence in one's own theories and endless patience in proving them, are more important than elaborately equipped laboratories in finding success in medical research.

Anna Caroline Maxwell, R.N., M.A.

1851–1929

IN Arlington cemetery, that burial place of the nation's great and brave, there was laid to rest on January 7, 1929, a very splendid soldier. She had no military titles. She was connected with no military unit. Yet Anna Caroline Maxwell had been a leader in nursing for half a century by virtue of her soldierly qualities, her courage, her foresight, the imperious quality of her will. Because of what she did for nursing and, through nursing, for the country, the nation paid her honor in her death.

It has been said of the services for Miss Maxwell that she would have loved their every detail. Lying in Maxwell Hall, in the serene majesty of the final peace, amid the exquisite luxuriance of the flowers of those who loved her best, she was surrounded by students and graduates who came to look their last and who found the beloved face beautiful in death.

In the Chapel of the Union Theological Seminary there assembled to do her honor a company of such distinction as gathers only for the truly great. Men and women representing not only medicine and nursing but every allied professional and social interest were there to do her honor.

The service was simple, including two of her favorite hymns, "Guide me, O thou great Jehovah" and "Dear Lord and Savior of mankind." It seemed peculiarly appropriate that Rev. Henry Sloan Coffin, D.D., should include in the reverently recited passages of scripture: "They that wait upon the Lord shall renew their strength" and he concluded his prayer with an epitome of her life:

> More especially we thank Thee for this Thy servant now at rest after long years of unremitting labor. For her upbringing in a godly home where early her spirit was dedicated to a career of ministry; for her large native endowment in an acute and orderly mind, in personal magnetism, in power to kindle enthusiasm and in gifts of leadership; for the training in home and school continued by strict self-discipline in after years; for her devotion to her chosen calling and the lofty ideal she cherished of it; for the vision and courage and unflagging industry as teacher and executive early recognized; for the post of responsibility to which she was chosen and where she proved herself worthy of the confidence reposed in her; for the many hundreds of nurses in whose education she had a share and who loved her in grateful and honored remembrance; for her patriotism and public spirit and readiness to answer the call of emergencies; for her practical outlook, free from sentimentality but aglow with passion for things true, just and helpful; for her capacity for friendship and for the loyalty she evoked from students and fellow-workers; for her hidden life of the soul with its reverence and faith and hope toward Thee, we offer our thanks.

To the strains of the "Chopin Funeral March" she was carried from the church, through a lane of uniformed nurses and was escorted by three groups of honorary pall-bearers; and here a precedent was established for her who had created many a precedent, for a group of women colleagues and close friends, Miss Nutting, Miss Goodrich, Miss Wald, Miss Clatworthy, Mrs. William K. Draper, and Mary Magoun Brown, were chosen for the posts of honor. Then came the representatives of the Medical Staff, Dean Darrach, Dr. William Palmer, Dr. Allen Whipple, Dr. John A. Hartwell, Dr. George A. Tuttle, Dr. George E. Brewer, Dr. J. O. Wheelwright, Dr. J. A. Miller, Dr. Linsley Williams, Dr. Ellsworth Eliott, Dr. William P. Northrup. Mr. Dean Sage and the Messrs. John Bush, Thatcher Brown, Robert DeForrest, Frederick Sturges, Moreau

Delano, and Dudley Peterson represented the Board of the hospital and the family.

Some twenty-five nurses and other friends from New York accompanied all that was mortal of Miss Maxwell to Washington for the interment. It was a glorious day on which she was laid to rest in Arlington, not far from Miss Delano with whom she was so closely associated in life. Full military honors were accorded her. Preceded by two Legion nurses, bearing the flag of our country and the flag of the American Legion, the casket, draped with the Stars and Stripes and the Red Cross flag, was borne on a caisson drawn by seven horses. It was flanked by the honorary pallbearers: Mrs. Mary E. Hickey, Veterans' Bureau; Miss Eleanor Gregg, Indian Bureau; Miss J. Beatrice Bowman, Navy Nurse Corps; Miss Lucy Minnegerode, U. S. Public Health Service; Miss Clara D. Noyes, American Red Cross; Major Julia C. Stimson, Army Nurse Corps; Miss Helen Young, Director, School of Nursing, Presbyterian Hospital, New York City; Miss Janet Fish, Director, School of Nursing, Emergency Hospital, Washington, D. C.; Miss Mary Magoun Brown and Mrs. Janet Christie, representing Presbyterian Hospital Alumnae. Following it was a company of soldiers, nurses in the uniforms of the Red Cross and of the government services, nurses with the Presbyterian colors on the left arm, and many more. An army band played "Lead, Kindly Light" and the cortege moved onward to the roll of drums. The impressive committal service was followed by three volleys from a firing squad and the poignant beauty of taps floated out in the soldiers' farewell and she was left to her long sleep surrounded by masses of flowers and in the company of our heroic dead.

A majestic figure, a gallant and vivid personality, a wise and witty friend passed from view when, on January 2, Miss Maxwell came to the end of her earthly life. A life of extraordinary usefulness and charm it was. The pages of our professional history bear eloquent testimony to her many-sided contributions to nursing. Splendid physical energy, great vitality, dynamic power that ceased only with the passing of life, these endowments enabled Miss Maxwell to fill the measure of her years to overflowing with generous service.

It is not life that matters but the courage you bring to it. Miss Maxwell never spared herself, and in all the changes and chances of her mortal life, it was her splendid and ever-renewed courage that made her great. The heritage of that example of dauntlessness and of humorous bravery is her greatest gift to the nurses who come after her.

"Indefatigability and intrepedity were her chief characteristics," says Miss Annie W. Goodrich, R.N., Dean of the Yale School of Nursing, a close friend of Miss Maxwell's for many years. "She was a soldier first of all with all the qualities of a soldier. She always knew what to do in an emergency—and sickness is an emergency."

It is probable that Miss Maxwell inherited a tradition for those soldierly qualities of foresight, courage, a keen grasp of a situation, a faculty for detail. Her father, John Eglinton Maxwell, came of a distinguished military family in Scotland where he was born. He, however, was graduated from the University of Edinburgh and was ordained a clergyman.

From the distaff side there were tendencies toward the strong positive qualities of the pioneer. Her mother was born in the United States of

As Taps Floated Out at Arlington

English descent, her ancestors having come to America in 1634.

Receiving her fundamental education from tutors in her home at Bristol, New York, Miss Maxwell later spent two years at boarding school and in 1874 received three months' obstetrical training at the New England Hospital where she had been assistant matron.

It was then she took the step that was to weld her inextricably into the very foundations of nursing in this country. In 1876 she entered the training school of the Boston City Hospital to which she was attracted by the fame of the superintendent, Linda Richards, the first American nurse.

Four great schools experienced the rare quality of Miss Maxwell's leadership. Immediately after her graduation, she was called to establish a school of nursing at the Montreal General Hospital. That effort was premature and after some months in Europe, where she visited a number of hospitals, Miss Maxwell, in 1882, took charge of the Boston Training School for Nurses connected with the Massachusetts General Hospital. In a well-established and conservative hospital progress necessarily was slow but nonetheless a nurses' residence was built within the hospital grounds, a night superintendent was added to the staff, a uniform for the students was considered and a badge for the graduates, the housekeeping care of the hospital wards was given into the hands of the superintendent of the training school.

It may have been because of the last-named experience that Miss Maxwell was able, some years later, to

give her keen and humorous warning to Dean Goodrich. It was Miss Goodrich's first superintendency and she sought Miss Maxwell for advice. When Miss Maxwell learned that the housekeeping fell within the jurisdiction of the superintendent she said, "You are going to be faced with all kinds of problems. Some day you will be told that four nurses are ill and off duty. Somehow you will have to see that the work goes on. But your real test will come when you are told that the cook and two of the maids have left without notice."

Miss Maxwell's gift for organization and leadership by now was recognized and in the spring of 1889 she was called upon to complete the establishment of the Training School for Nurses of St. Luke's Hospital, New York City, where she remained until the fall of 1891.

She then accepted an appointment to establish the school of nursing of Presbyterian Hospital, New York City, undertaking her duties January 1, 1892, the school which stands preëminently as her life work. She had not been there long before she had drawn into the ranks of the student nurses, young women of culture, background, and education. Thus was emphasized the need for the highest type of woman in the nursing profession. This and her later exploits in military nursing were doubtless factors to which she owed the journalistic title of the American Florence Nightingale.

Miss Maxwell remained as superintendent of the Presbyterian school until 1921 when at the age of 70, she resigned from active leadership. When the retirement came how regally it was done—head up, eyes front gazing to a future wherein might lie the leisure to do many things she always had enjoyed, fuller contacts with her many friends, travel, plans for the equipment of the new residence for nurses that now bears her name.

Then illness came and she was a patient when the day arrived to move from the old Presbyterian hospital buildings to the new medical center. What more fitting than that she should be the first patient transferred to the new Harkness Pavilion for private patients. When the new medical center was opened in the autumn of 1928 Miss Maxwell, still dauntless and keenly interested though in a wheelchair, was present at the ceremonies.

Another ceremony, however, was abandoned because of her failing health. An official presentation had been planned whereby a representative of the French Government should award the *Medaille d'Hygiene Publique* to four women who had made conspicuous contributions in the American nursing profession to the advancement of nursing throughout the world. Miss Maxwell was to have been the principal recipient at the ceremony. Instead of the elaborate formality which had been arranged for this event, a simple ceremony took place in December, 1928, beside Miss Maxwell's bed.

A hand-illuminated parchment, setting forth the citation of the French Government, and a gold medal were presented to her by Dr. Charles Burlingame, Chairman of the Advisory Board of the American Hospital in Paris. Others receiving the citation and a silver medal were Major Julia C. Stimson, Superintendent of the Army Nurse Corps, Washington, D. C.; Annie W. Goodrich, Director of the School of Nursing, Yale University; and Clara D. Noyes, National Director of Nursing Service, American Red Cross, Washington, D. C.

Thus in the school to which she had

given thirty years of active leadership, did Miss Maxwell receive her final recognition of achievement and there a month later, she died. The school that meant so much to her mourns her passing as a daughter grieves for the loss of her mother. Her name is carved in stone over the entrance to the new school residence, that stately pile which towers above the sweep of Hudson where the medical center vies with the palisades in impressive dignity. But deep though this carving be, Miss Maxwell's name is inscribed more deeply still in the minds and hearts of her nurses.

A soldier Miss Maxwell was through all those years and a soldier she proved herself to be in the emergency of war. In the summer of 1898, during the Spanish-American war, an epidemic of typhoid broke out at Camp Thomas at Chickamauga Park, Georgia, where 50,000 men were being trained.

The third auxiliary, American Red Cross, raised funds to send out a corps of nurses to meet the emergency and Miss Maxwell secured leave from the training school to take charge of the nurses at Sternberg Hospital, Camp Thomas. She and her nurses arrived July 29. They found chaotic conditions. Only tents and beds were in readiness to receive the first 126 patients. Necessary supplies and equipment had not been unpacked. The men themselves were in a most deplorable condition due to lack of proper care.

There were more than 600 typhoid cases besides which there was in the camp considerable malaria and an epidemic of measles. After Miss Maxwell took charge there were only 67 deaths out of the thousand cases admitted to the hospital.

It was at the conclusion of the Chickamauga episode that Colonel John Van Rensselaer Hoff paid that now classic tribute to Miss Maxwell. He said, "When you were coming, we did not know what we would do with you. Now we wonder what we would have done without you."

After the Spanish-American war a committee was formed with Miss Maxwell among its members, to secure an act of Congress to establish a corps of nurses prepared to care for soldiers in the event of war. One bill was defeated but through the continued efforts of the committee, the War Department was incited to bring forward a bill of its own and the Army Nurse Corps thus was created as part of the military establishment of the United States Army. Likewise she was a member of the committee which formulated plans for the Red Cross Nursing Service which became a Reserve for the Army and Navy Nurse corps.

When the Great War broke out, Miss Maxwell became Chief Nurse of the unit of Presbyterian Hospital, part of the measures of preparedness undertaken by the American Red Cross. In 1916 Miss Maxwell visited the hospitals in the war zone, going to the three fronts, and returning with a better understanding of nurses' work in a military organization.

Unfortunately, Miss Maxwell was over age for active service—a fact that must have irked her considerably when the United States entered the war and the nurses of the unit, which became U. S. Army Base Hospital Number 2, saw active service under her able assistants. There was plenty to be done at home, however. Miss Noyes asked Miss Maxwell to form a committee of chief nurses in New York to choose and negotiate for uniforms for the nurse units going overseas. The British had asked for six units, consisting of medical, nursing, and orderly personnel to replace

their hospital staffs. One unit already had sailed and two had to be equipped to sail within a week. The committee was able to secure the services of a firm which produced 300 uniforms in six days.

When the weight of the work was lifted at home, Miss Maxwell, early in 1918 went to France where she visited the Presbyterian unit at Etretat. In memory of those army days, the Red Cross flag that flew above her hut at Chickamauga and over her tent at Etretat of late years has been placed above her table at alumnae banquets.

Such in brief outline was the earthly life of Anna C. Maxwell. To fill the pages is to record days literally overflowing with activity. She loved people, enjoyed social intercourse, and because of her physical strength she was able to indulge her pleasure in social things. It is said of her that after a strenuous day—and what day was not strenuous—Miss Maxwell would go out in the evening, would return about midnight, work for awhile, throw herself on the bed, and be up again ready for another day at five-thirty the next morning.

She maintained active relationships with the Cosmopolitan Club, The Woman's City Club of New York, and the National Institute of Social Science, as well as in her multitudinous professional organizations. Dean Goodrich recalls the vivid picture of Miss Maxwell, as Christopher Columbus, seated on the steps of Queen Isabella's throne in a pageant at the Cosmopolitan Club. Miss Maxwell was then about 70 years old and in her carriage and on her face was written a lifetime of living. Erect in bearing, head high, face lined with years of thought and care, of humor and self-giving, eyes keen and bright with the zest for living (an amazing zest for life, Miss Nutting describes it)—no one could have portrayed better the care-worn captain of a little fleet that dared the unknown, defied danger—and found joy in the adventure.

The fifty full years of Miss Maxwell's work as a nurse, saw nursing grow into a great profession. It is difficult to estimate her contribution to this growth because she was so much a part of it, so actively a leader in all that was connected with nursing. Her interest in the *Journal* was typical of her interest in the whole profession. In the later years when she had leisure for much travel, it was her custom to send to the editor from here, there or yonder—and in the weary last months from her bed—little notes to call to attention the significant though non-spectacular occurrences which seemed to her important. No important professional activity escaped her notice. But for one achievement Miss Maxwell stands alone. There can be no doubt whatever but that Miss Maxwell instituted the standardization of nursing technic and procedure. Other hospitals later developed, amplified, and improved upon her methods, but the inauguration of demonstrations of nursing technic and equipment was conceived by Miss Maxwell, developed by her for the use of her own students, and finally made public.

The last-named step was urged by the president of the board of trustees who, having recognized the great value of these demonstrations, asked Miss Maxwell if she would present them before a selected group of nurse leaders in New York City. In the "History of American Red Cross Nursing" it is stated that "it may be truly said of Miss Maxwell that no appeal for help that it was possibly in her power to give, was ever made to her in vain." She consented now

to the request for making public her demonstration method. And on a certain evening a group of nursing and medical leaders gathered in the amphitheater of old Presbyterian hospital to witness the first demonstrations of nurse technic and procedure evolved in the United States.

To Miss Maxwell's grasp of the existing conditions in nursing with their needs and their possibilities, to her faculty for looking forward to future needs and to ultimate eventualities, to her genius for detail, is attributable the demonstration method in nursing procedures, a worthy contribution from a great leader to her growing profession.

Her personal attributes are written into her life. There was a majesty about Miss Maxwell and an imperious quality in her will that secured obedience. A veritable genius for precise methods made her an able administrator and a teacher of rare force, a spirit of gallant sportsmanship and a quiet constant humor smoothed the rough places. A quick tongue and a ready wit softened the way.

Dr. William Darrach, Dean of the Medical School of Columbia University, knew Miss Maxwell when he was house surgeon, attending surgeon, and recently as dean. He tells of meeting her one morning in a corridor. "Good morning, Dr. Darrach," she said. "I see you have a case of tetanus on your ward." "Oh, no, Miss Maxwell, we have no tetanus," denied the doctor. Two days later a diagnosis of tetanus was made. But the whole conversation had been carried out in so entirely impersonal a fashion that no offense was given and the doctor was left with a feeling of respect for her judgment.

A social being was Miss Maxwell with a rare gift of friendship, an intimate, individual touch such as made one of her graduates on a Christmas Eve exclaim over a small well-chosen gift, "Isn't it just like the chief to send exactly the right thing."

The three qualities that stand out in Dr. Darrach's mind as embodied in the character of Miss Maxwell were her rare combination of vision, a really amazing ability to look ahead and see what the future would bring, courage in carrying out her ideas after she had decided on a course of action (she had not the slightest fear of any man, be he dean or president of the board or a Vanderbilt); and a strict insistence upon thoroughness in all that was done.

Dr. James Alexander Miller of New York, another of the Presbyterian men who have won distinction, was long associated with Miss Maxwell. At the time of her death he wrote:

> It was my privilege to know Miss Maxwell intimately during the period of her greatest activity and probably highest efficiency. Her influence upon all of us at Presbyterian Hospital, physicians, nurses, and laymen alike, was very remarkable.
>
> She combined an unusual executive ability with a keen vision of the possibilities of nursing service, and a personality of rare charm. Those of us who sat at the staff table with her in the old Presbyterian days will never forget the way in which she kept the ball of conversation rolling with keen wit and swift repartee. Her contribution to the general cause of nursing education is a matter of public record, but it is the recollection of those days of intimate association with her which I shall always treasure in my memory as having been a very unusual privilege.

Miss Adelaide M. Nutting of Teachers College, Columbia University, wrote:

> Many memories crowd upon me tonight as I think of her devotion to her calling, her sincere belief in its dignity and worth, and of the trends of her efforts toward its betterment. I am recalling her magnificent vitality, her courage, the tenacity of purpose which carried her so valiantly through the many years of intense and continuous activity. Of her exacting physical labors, and of the

constant mental effort necessary in adjusting these to new conditions, situations and persons; of the large executive tasks of a kind almost peculiar to nursing, involving wide responsibilities on the one hand, and the direct handling of much detail on the other. Of that detail she had notable mastery; to the executive duties she brought the aptitudes of the "born" organizer, a love of order, courage, shrewd foresight, untiring industry, and the kind of leadership which made people want to work with her—an executive who enjoyed her task.

She was of the old school, firm in the traditions of her generation, guarding and cherishing them. The ideas prevalent when she began her work, and still existing in some measure, were that nursing was a calling which required of its votaries complete absorption in their task, and almost complete isolation from the normal human interests and social relationships of life. The ideal in fact of the religious orders.

Yet Miss Maxwell's ordering of her own life was a distinct and wholesome protest against any such view of nursing, against any such traditions of useless self-sacrifice, of immolation on any altar whatever. She greatly enjoyed the pageant of life, had keen appreciation of beauty, culture, music, art. She loved travel and had a positive "flair" for the adventurous side of life. She had marked social gifts and was seldom too tired to use them. Though living an arduous life as the busy head of a great professional school, she found time to draw to herself a large circle of friends quite outside of professional relationships, and established for herself an honored place among them. In so doing she enlarged public respect for the work she represented. Nursing became through her a more desirable and attractive occupation to young women of good education and upbringing, and the sick benefited by a finer care, a higher degree of intelligence and devotion.

It needs no imagination to realize the value of the influence thus exerted upon a young profession at a critical period of its history when it was of paramount importance that new ideals and standards of work should be created and maintained. The quality of work was dependent upon the quality of the worker.

No one who was at all closely connected with Miss Maxwell could fail to note the generous spirit with which she met those who came to her for help or advice in working out or carrying out some new idea or plan. Her first impulse was to help, to see what could be done to bring the thing about, her coöperation was real, active, resourceful. She brought something very stanch and dependable to the causes in which her energies were enlisted, and to the developments in nursing during the forty years of her active working life, she gave unstintingly of her very best.

Frances A. Stone, a Presbyterian graduate of the first class, 1894, who was Miss Maxwell's assistant for many years, says of her:

Miss Maxwell will always occupy her place in our hearts and minds as an unusual woman, a charming personality, her standards the highest, her powers of endurance remarkable. Dominating, compelling, and graciously leading, she was always entirely unconscious of self, an inspiration for all who worked with her. Looking toward a goal, she never faltered until the best was accomplished. Strong, with the ability and charm of a genius, human through her weaknesses, she was first of all a woman's woman. When a call came, or need appeared, all time was at her disposal and she gave freely of her best. No one could fail to find comfort, renewed courage and inspiration when seeking her counsel.

And after her death *The New York Times* concluded an editorial concerning Miss Maxwell by saying:

Her name will be cherished as long as even one of her graduates lives, and will be written imperishably in the annals of nursing in America.

It was some years ago that Dean Goodrich paid a tribute to Miss Maxwell which the years have only intensified and made more real:

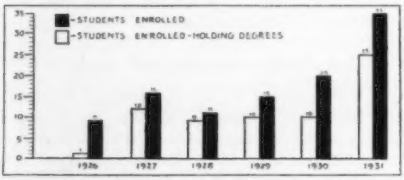
"Soldier through her sense of duty and her fearlessness of danger,
Teacher through her love of giving all the knowledge she was heir to, like a spendthrift.
Counting nothing, so she helped one on and upward to the summit of their life work,
First and last and always, Mother, through her tender ministrations to the young and sick and helpless,
That's the woman as I see her not a dew-drop, not a plaything,
For your poets or your princes, but a splendid great creation,
From the Master Builder's workshop for the healing of the nation."

Yale School Endowed

ANNIE W. GOODRICH, D.Sc., R.N.

THE Yale University School of Nursing, now entering upon its sixth year, is privileged to announce that the Rockefeller Foundation, to which the school is already indebted for an experiment in nursing education that has commanded world-wide attention, has now ensured its permanency by an endowment of a million dollars, the yearly income of which is to be applied to the educational program.

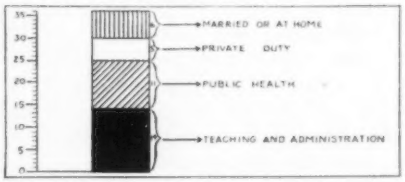
It is with, we hope, pardonable satisfaction that we review the accomplishments of these few years. The slow but steady growth in the enrollment, now totalling 116, the strengthening of the educational qualifications of the students, all now coming to us with at least two years of college and a large majority holding a Bachelor's degree, and the fields that the graduates, 36 in number, have entered (as illustrated by the accompanying graphs), are gratifying evi-



dence of the place the school is establishing in the public mind.

Of hardly less importance than the development of the student body has been the contribution to the community's health program through the affiliations that have been effected with the smaller schools in the surrounding country, from which 746 students have come for courses ranging from three to fifteen months and under the instructors responsible for educational principles embodied in the Yale curriculum.

And lastly we have been privileged to receive, both as guests and students, nurses from all over the world keen to observe and study the methods of the school. A total, in this short period, of over a thousand who have participated in the program of nursing education—a program unique in that the principles of preventive not less than of curative medicine are included in the basic course.



To the faculty of the school the endowment, as evidence of the approval of the Rockefeller Foundation of the achievements of these past five years and of confidence in the future growth and development of the school, is immensely heartening.

For the nursing profession this great gift and the splendid endowment of the School of Nursing of Western Reserve University herald the dawn of a day long awaited by those concerned to forward nursing to its most effective ends; ends only to be achieved, however, through the provision of means whereby, without detriment to the patients or interference with the hospital routine, the content of professional education determined as essential can be assured each student.

There is a great future before the nursing profession. Under the scrutiny of science the scope of its many branches widens and deepens so

infinitely that the past interpretation of the nurse's function seems disturbingly superficial. In every branch, Surgery, Medicine, Pediatrics, experts are needed and are not yet to be found. The centralization of schools which is now an accepted objective will demand full-time instructors in the various sciences, such as anatomy, bacteriology and the like. The call is loud for experimentation, for research in many directions, and the publication of such findings.

Here is not cause for discouragement, but rather for rejoicing since these are all signs of abundant life. Further and equally great gifts are indeed needed, but they will be forthcoming. How little did we dream, a few decades past, that in the year 1929 the schools of nursing having some connection with universities would number one hundred!

We are confident that we are speaking not only for the faculty, the graduates and the students of the Yale University School of Nursing, but for our many thousands of colleagues in nursing when we express our profound gratitude to the Rockefeller Foundation for its princely gift; to the President and Corporation of this old and renowned institution of learning for over-riding tradition to open its doors to a new educational expression; and to the New Haven Hospital that has accepted the burden such an experiment inevitably imposed.

A Nurses' Window

INSPIRING dignity is given to the foyer of the new Presbyterian Hospital in Newark, New Jersey, by a group of windows, a gift to the hospital, which were developed around the concept of idealism combined with scientific preparation for service.

The central window, dedicated to the Trustees of the Hospital, is a beautifully executed group depicting Christ healing the sick. The inscription of this window reads, "I am among you as One who serveth."

The window to the right, dedicated to American physicians, contains simply the Caduceus.

The nurses' window, to the left of the central window, is focussed upon the device of the Greek lamp. These two windows are identical in color and impress all who understand their symbolism with the dominating motive of the hospital, sound preparation for Christian service.

At the dedication of the nurses' window which bears the inscription "not to be ministered unto, but to minister," the symbolic beauty of the concept of the lamp in relation to nursing was brought out by reference to the "Lady of the Lamp" who has for all time raised high the torch of service. Emphasis was placed on the lamp as the symbol of knowledge and the hope expressed that all nurses coming under the influence of the lovely windows might never forget that true service, while rooted in idealism, must be supported by knowledge.

St. Luke's Hospital, Tokyo

ON November 9, the Rockefeller Foundation appropriated $400,000 for maintenance of the educational features of the school of nursing at St. Luke's Hospital, Tokyo. An interesting account of the work of this school, described by Araki San, its Superintendent, appeared in the *Journal* for October, 1927.

Editorials

A. N. A. to Study Registries and Private Duty

ONE of the first matters to be taken under consideration by the Board of the American Nurses' Association at its annual meeting in New York City during the week of January 14 was that of the serious economic problems of private duty nurses. These were brought into the limelight by "Nurses, Patients and Pocketbooks," and the facts there presented by the Grading Committee have been the basis for much thoughtful study by the national organization. At the Board meeting the following resolution was presented:

> Believing that, as evidenced by the findings of the Grading Committee, the most immediate problem of the American Nurses' Association is that of the private duty nurse and the means through which she may best serve those who need her, the Headquarters Committee recommends that an additional member be added to the Headquarters staff, whose primary function shall be the study of registries and their relationship to the distribution of nursing service.

The Board, in acting upon the resolution, not only accepted it in toto but voted to make a special appropriation from the funds of the Association for the work.

The good news for private duty nurses came to the editor's desk just as the *Journal* pages were closing. Subsequent issues will carry details of the plan and report the progress of the work.

The agenda for the meetings of the Board are of unusual interest. The members are studying the problems presented by the various committees and by the secretaries at Headquarters with vigor and enthusiasm. The days are crowded ones for, as always, great effort is being made to conserve the time of the workers and the funds of the organizations. Committees meet early and late. The Headquarters offices buzz with activity such as is not easily portrayed to the nurses who have never visited the offices that exist solely to help them in their work.

This first news which we are authorized to relay is of the utmost importance to private duty nurses, that great branch of the profession which constitutes more than 50 per cent of its numbers. Next month's *Journal* will have further news, and news of importance to other groups from both the A. N. A. Board and from that of the N. L. N. E.

Special Duty

IS it because our schools are filled to capacity with students that the cry of "too much student specializing" has arisen again? We had hoped the practice of using student nurses on special duty, except for the valuable experience to be gained on a few carefully selected and carefully supervised cases during periods when no class work was being given, had become a thing of the past, and that such assignments were now based on sound educational technic. Seemingly this is not the case and it was not virtue but necessity that kept the dubious practice in abeyance in the post-war years when the enrollment of the students was relatively small.

In one section of the country where private duty nurses graduated from the local schools are seriously in want, we are told that students are being liberally used on special duty. An aggressive attitude on the part of the graduates, who feel that their bread and butter is being taken away from them, apparently aggravates the situation and the institutions cling to their right to use whom they choose for service to their patients. If students are really more desirable than graduates, we are moved to inquire somewhat caustically of such schools; "What kind of graduates have you been turning out?" and with equal justice of the graduates: "Have you actually demonstrated that you are more competent than the students?"

The question, "Which service is easier to administer?" is usually answered in favor of the student specials, and there is food for thought for graduates here. Have any alumnae members ever conferred on ways of improving the special-duty service in the home hospital? Such conferences between the alumnae association, or its chosen representatives, and the superintendent of nurses and the appropriate supervisors, could be made a far-reaching and constructive force, if conducted in a spirit of mutual helpfulness. Out of them might come needed reforms in nursing service and equally needed reforms in the facilities provided for "specials."

If the hospitals are receiving money for the service of the students, the schools are open to a charge of exploitation which could be downed only by providing teaching and supervision of a very high order and by a searching analysis of the costs of teaching and of the value of student nursing, such as has not yet been attempted in most hospitals.

Probably only those who have actually directed hospital nursing services can comprehend the difficulties and the kinds of pressure the superintendents have to withstand. There is the pressure of the service itself. Few indeed are the superintendents who can be sure that the service is at all times adequate to the needs of the patients. There is the constant question of the cost of nursing service, cost to the patient and cost to the hospital. There is the traditional attitude of the alumnae: "You graduated us, here we are, why don't you employ us?" There is the all-important question of personality. Even a superior nurse is sometimes disqualified by some personal quality, for a particular case. There is the always difficult problem of social relationships. Some nurses fit in almost anywhere; some have to be placed with care and these, if not gifted with the power to see themselves as others see them, become resentful when not called in turn. It requires great wisdom and sound judgment of social and educational values to deal justly with all the phases of the problem. Fortunate is the director of a nursing service who has thought through her problem and come out with a set of basic principles; principles, not prejudices, to which she consistently adheres and which are respected by those with whom she works and who are qualified to judge.

The question, "What is the student in the school *for?*" can be answered in only one way. She is in the school to receive a well-balanced preparation for service as a graduate nurse. Most hospitals justify the use of funds for nursing education only on the basis of the value of the student-nurse service to patients. If she is put on "special" it must be because she can learn enough on that one case to compensate for the loss of time on a more active service. It is assumed that she is learning

while doing and paying her way in service. The hospital which receives compensation for the service is always open to the bitter charge of "exploitation." With an abundance of students, obviously it is easier to put a student on special than to call a graduate. In the past this had a substantial basis in fact and at least one state still has a regulation limiting the amount of special nursing students may do and adds, "Neither hospital nor nurse shall receive a fee for such work."

The studies of the Grading Committee indicate a serious over-supply of graduate nurses in many places. It is common knowledge that most schools have all the students they can house, which is not always synonymous with the number of students for whom they actually have clinical experience. Now comes a resurrection of the old question of student specials. As a matter of social justice, with sympathy for the administrators of our complex nursing services, but with sympathy also for students and "specials" we ask, How long can hospitals expect to follow blindly the path of least resistance?

Heartless Nurses

IN the January *Journal* we placed much stress on our plans for securing material on nursing procedure and we mentioned the safety, comfort and happiness of the patient among the objectives of procedure. We were thinking of the nursing service as the very heart of the hospital, which is as it should be. The correspondent who some time ago sent us "Heartless Nurses," which appears in the *Forum* this month, was not speaking of an isolated case. Obviously the nursing care, as such, was not good, but she cited instances in several other hospitals of appalling indifference to the appeal of the suffering for sympathy and human understanding as well as for proper physical care. This seems to us fully as serious as the lack of proper technic, for it indicates an utter lack of that impulse to nurture which motivates all good nurses.

Lest this one correspondent might have been unusually unfortunate in her experience outside her own institution, we tried out the material on nurse visitors to headquarters. We asked them if such things really happen. Invariably they expressed horror that such things could be, and some of them capped the experiences of our correspondent with equally vivid tales of callous indifference in yet other institutions.

What does it mean? Is the spirit of nursing dead or dying? Do we allow what is normally warm human sympathy to be killed by hospital rules that decree that all medical information shall be obtained from the doctors? Do we tend to let rule and routine destroy sympathy, initiative, tact and lovingkindness? Nurses, good nurses, are keenly sensitive to changes in the physical and mental condition of patients. If they have any claim whatsoever to the term professional, they are also sensitive to what a change for the worse may mean to the friends of a patient, even when he himself may be beyond caring.

The discretionary powers vested in good nurses by institutions and by the medical profession are very great. Only a soulless machine, and very few hospitals are really that, has rules so arbitrary that a nurse may not answer the anxious questions of the harassed friends of patients with sympathy and tact. The brief answer, "Ask the doctor," saves the nurse's time but her time is rarely so valuable that she cannot at the moment, or within a reasonable time,

explain the reason for the rule and help the inquirer to secure the satisfaction of a fair answer to his question from the proper source.

Nurses who are really concerned with the welfare of their patients, and of course they are in the majority, accept the responsibility for helping patients and their friends to adjust to the complex machinery of the modern hospital. The nurse is nearer to the patient than is medical staff or administrator. It is in her power to so interpret rulings that she helps the institution to surround its patients with interest and sympathy. If she lacks the spirit of nursing and is at heart just a factory worker, a mechanistic routineer, putting as little as possible of mental and physical energy into her work, she finds herself in an increasingly arid and unhappy atmosphere. Finally it is discovered that not only the patients are dissatisfied but she too must look without the walls for the satisfaction which so richly might be hers if she would but look within and make the most of her opportunities.

Modern ingenuity has equipped our hospitals with extraordinary facilities for the care of the sick. What price equipment, if it be not used with skill, blended with sympathy and tact? It was a great hospital administrator who first called nursing "the heart of the hospital." It functions smoothly, suavely, efficiently, happily in most institutions, and only when it so functions can patients receive the full benefit of the wealth of scientific apparatus provided for his care. If the administration is really arbitrary and unfeeling in its rulings, if the perennial thread of red ink on the ledger pages gives rise to a cold mercenary atmosphere that permeates the whole institution like a blight, even the best of nurses are powerless and the heart ceases to function as it should.

The 1929 Calendar, Historic Hospitals

THIS year the nurses, through the League, have sold more calendars than ever before in the history of calendar sales. Figures for comparison are as follows:

1925	calendar	—Leaders in Nursing..	11,145
1926	"	—The Nurse in Poetry.	12,676
1927	"	—The Hospital in Poetry.....	12,160
1928	"	—Quotations.....	10,180
1929	"	—Historic Hospitals...	13,562 to Jan. 4, 1929

Figures of sales cover the period until about July of each year, when sales usually stop.

This splendid record has been made possible only through the united efforts of everyone. State committees have done much hard work in pushing sales. The states which have "gone over the top," and exceeded their previous records have had organization and coöperation from all nurses, and we see how well it has worked out. It all goes to prove that what other people say about us is true, nurses can do what they set out to do. It furthermore shows that nurses appreciate that the League is working for them all, and that its work is a part of theirs, to make things better in the nursing world, with better workers for the future, and better economics. Because of the support of the nurses, both in spirit and financially, the League hopes to be able to do much more for and with them this coming year.

Eminent Teachers

Lydia E. Anderson, R.N., B.S.

An Appreciation

BERTHA H. LEHMKUHL, R.N.

IN the panorama of life there are scenes which stand out clearly and which time cannot blot. Every nurse recalls her first impression of her school, her first lesson in the classroom.

Thus memory travels two decades into the past and produces a friendly figure, simply clad in a black alpaca with white collar and cuffs, facing a group of expectant yet rather timid young women to introduce them to the intricacies and marvels of the sciences of human life. Then and now so simply it is done, that life itself speaks through her teaching; so understandingly that even to the hesitating mind the mysteries of life are unfolded clearly and reverently; so humanly, that bodily weariness is forgotten and the ward work is resumed with keener interest, a brighter eye and a warmer smile.

Never was there a problem, a conflict with ideals which could not be carried to this teacher, to which she did not freely give of her sympathy and wise counsel; for she always possessed the happy faculty of divining means of adjustment, while holding firmly to the principles of her profession. No festivity or class reunion was ever complete without this tried and trusted friend; her wit and spontaneous humor were a constant source of inspiration to cheer and good fellowship. So truly was the bond strengthened between teacher and pupil in work and in play.

Lydia Elizabeth Anderson, the daughter of the Rev. Thomas D. Anderson, D.D., and Lucy Spence Anderson, was born in the city of New York, where her father was pastor of the First Baptist Church. Her education was obtained in private schools and completed at the Rutgers Female College. Dr. Anderson's acceptance of a call to a Boston parish led to several years' residence in that city until, in 1895, Miss Anderson entered the New York Hospital Training School for Nurses, from which school she was graduated in 1897. In the same year she became Associate Superintendent of Nurses of the Sloane Maternity Hospital. She resigned, in 1902, to gain a year's experience in private duty. Then followed an associate superintendentship of nurses of one year at the Long Island College Hospital, and another of four years at the Mount Sinai Hospital. In September, 1909, Miss Anderson entered Teachers College for several courses, and also gave some lectures. At this time she started upon her long and successful career of visiting instructor. Her first schools were the Mount Sinai Training School and the school of her Alma Mater. Her field of instruction has since then included the schools of the following hospitals:

Brooklyn, Bushwick, Long Island College, Methodist Episcopal, Norwegian, Peck Memorial, Prospect Heights, St. Catherine's, St. John's, St. Mary's and Wyckoff Heights, of Brooklyn; Flower, Italian, Nursery and Child's, Post-Graduate, Presbyterian, Sloane Hospital for Women, St. Luke's, St. Mark's, St. Vincent's and The Woman's, of New York; St. Joseph's of Yonkers; White Plains; Jersey City and Christ Hospital, of Jersey City; St. Barnabas, of Newark; Mountainside, Montclair; Memorial, Orange, New Jersey.

LYDIA E. ANDERSON, R.N.

She has taught uninterruptedly since the beginning of her work as a visiting instructor at the New York and at the Methodist Episcopal hospitals.

In 1910 Miss Anderson was appointed to the New York State Board of Nurse Examiners. She served one year as secretary of this Board and seven years as president. Until her resignation in 1927, she remained an active member of the Board.

As the years have passed, each one of them has opened the doors wider and yet wider to the heart of a great teacher and a beloved friend whose life, in the words of Phillips Brooks, may well be said to interpret "Holiness: an infinite compassion for others; Greatness: to take the common things of life and walk truly among them; Happiness: a great love and much serving."

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY LAURA R. LOGAN, R.N.

Psychological Tests Applied to Nurses in Training at the Rhode Island Hospital[1]

ANDREW H. MACPHAIL

INTELLIGENCE tests are proving to be of value in nursing schools that have given them a serious trial, and for that reason the Committee on Nurses from the Board of Trustees of the Rhode Island Hospital was led to feel confident that such tests would prove to be of value at that institution also. In February, 1928, such action was taken as was necessary to institute a program involving the administration of psychological tests to the students then in training and providing for a study of the results to discover what diagnostic or prognostic value such tests might possess. In the initiating of this program, it has been the privilege of the writer to assist the hospital authorities. Even in the very short time over which the study has been conducted, the results thus far obtained appear to be of sufficient significance to make them known to others who are engaged in the training of nurses.

It appears that many, and probably most, of the studies thus far appearing in print bearing upon the administration of psychological tests to nurses in training have been largely confined to the reporting of comparative results, and less attention has been given to the values of scores on psychological tests as a means of predicting probable success or failure in the training process. The present statement includes both features, but by far the more valuable portion will be that devoted to the follow-up studies.

A study of such comparative data as are available indicates that, in terms of general intelligence, the probationers and those who survive that period and are retained for further training at the Rhode Island Hospital compare very favorably with corresponding groups at other similar institutions.

In 1924 H. H. Young[2] reported that a group of 101 student nurses in the Indiana University Training School for Nurses, Robert W. Long Hospital, made a median percentile rank score on the Indiana Mental Survey Test—Schedule D, 8 points higher than that of Seniors at large in the high schools of that state. These 101 student nurses had survived the six months' probationary period. The intelligence rating of the student nurses who had survived the probationary period in the Rhode Island

[1] This study is made possible through coöperation with John M. Peters, M.D., Superintendent, Helen O. Potter, R.N., Superintendent of Nurses, and Mary H. Paterson, R.N., Instructor of Theory in the Training School.

[2] Young, H. H., "Intelligence Ratings and Success of Nurses in Training," in *Journal of Applied Psychology*, Vol. VIII, No. 4; pp. 377–389, December, 1924.

Hospital compares very favorably with the Indiana University student nurses since their median score on the Brown Test had a percentile value 18 points higher than the median for high school Senior girls at large and 12 points higher than the median for high school Seniors (both sexes).[3]

In 1926 M. G. Earle[4] reported a median score of 110 on the Army Alpha for 212 student nurses in seven large hospitals in New York City. Two of the groups tested were probationers and presumably the remainder had passed that period. Data obtained at Brown University by the giving of the Army Alpha and the Brown University Psychological Examination make it possible to convert Alpha scores into the approximately equivalent score on the Brown test. By such conversion, it is evident that, as groups, the probationers at the Rhode Island Hospital and the 212 New York City student nurses are approximately identical with respect to general intelligence with probably a slight margin in favor of the former.

To discover whether or not scores on the psychological tests possessed any predictive value, a careful study was made of the records of the probationers during their first several months in the training school, *i. e.*, from February to June, 1928. During this period most of the work is of an academic sort and there were available the complete records of thirty-five students in twelve courses. The records of five other students were not included in the study because of incompleteness, but what information was available indicated that the final results have not been altered significantly by the omission. A coefficient of correlation of .76 was found between the scores on the Brown University Psychological Examination and the average academic grade during the probationary period. This is a higher degree of correlation than is commonly found in the secondary or collegiate field. The practical significance of this index is explained in the following paragraphs and can be better understood by an examination of the accompanying diagram.

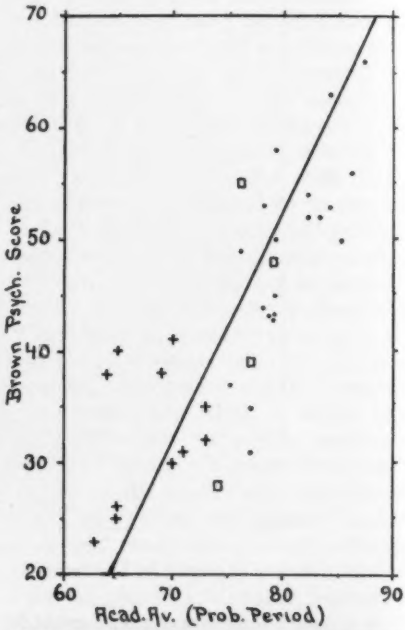


Diagram showing correlation between scores on the Brown Test and academic averages (35 Probationers: r = .76).

Notes on Diagram.—Crosses indicate students dropped at the end of the probationary period. Squares indicate students accepted "on condition" as juniors. The diagonal line has been determined mathematically as the best straight line to indicate the trend of relationship when considering Brown psychological scores as predictive criteria.

[3] Colvin, S. S. and MacPhail, A. H., "Intelligence of Seniors in the High Schools of Massachusetts," U. S. Bureau of Education, Bulletin No. 9, 1924, page 7.

[4] Earle, May G., "The Relation between Personality and Character Traits and Intelligence"; *Journal of Applied Psychology*, Vol. X, No. 4; pp. 453–461; December, 1926.

At the close of the probationary period, certain students are "accepted into the school" to go on with their training, a few are accepted "on condition," and others are not accepted. The latter are formally refused registration and leave the institution. Any criterion that is distinctly better than a mere guess in predicting which students are likely to be accepted for training beyond the probationary period, and which are not, is of distinct value. The earlier in the process that such predictions can be made, why, of course, the better. The whole scheme of selecting individuals for admission to our various educational institutions operates fundamentally on the principle of predictive criteria. In the educational field, performance on a reliable and valid psychological test has been found to be one of the most valuable criteria. It was not altogether surprising, as has already been suggested, to find that, for the group of probationers being studied, psychological test scores apparently possessed very remarkable significance. This significance was found to operate not simply in indicating very probable success, but also very probable failure. The data show that, out of 5 who scored below 30 on the Brown Test, none did satisfactory work; out of 8 scoring below 35, only 1 did satisfactory work; and out of 16 scoring below 45, only 3 did satisfactorily. However, out of 19 scoring above 45, all did satisfactory work with the exception of 2 who were conditioned but were allowed to continue their training. It is not usual to find the line of cleavage quite so clearly drawn as is the case here. The whole relationship can be more briefly stated as follows. Among probationers who score *above* 45 on the Brown Test, nine out of ten succeed and among probationers who score *less than* 45 on the Brown Test, eight out of ten fail. Success and failure here apply to survival of the probationary period and acceptance for further training as Juniors. The diagram shows graphically the basis of this summary statement.

A study of the average grades received by 32 Juniors shows that the predictive significance of psychological scores may be expected to extend beyond the probationary period. For this group, a coefficient of correlation of .50 was found which compares very favorably with typical results obtained with high school Senior groups and in women's colleges. In this Junior group, no student who was *below* the average for the group on the psychological test had an academic average as high as 85 per cent. Conversely, no one *above* the average psychologically had an academic average below 75 per cent. The presence of this amount of significance of psychological scores among Juniors, although less than among probationers, is sufficient reason for expecting that psychological scores made by students just entering upon their probationary period will possess a predictive significance that will apply to their careers as Juniors. In other words, it is expected with considerable assurance that, as the study of the careers of the probationers who entered last February goes on, the psychological test scores will continue to retain sufficient significance to serve as valuable aids to those in charge of the training work.

In September, 1928, the Brown University Psychological Examination was given to 61 students just entering upon their probationary period. If the predictive significance of scores on this test, determined as already described in this statement, be applied to the scores made by this

group, only 50 per cent, approximately, may be expected to successfully complete their probationary work. Should this turn out to be an actuality, the present group will have exhibited the same degree of mortality as their next immediate predecessors.

Mental and Physical Factors Essential to Good Nursing[1]

Some of the Mental and Physical Factors Essential to the Production of Good Nurses or, Better Still, the Mental and Physical Factors Essential to the Production of Young Women Able To Face the Realities of Life With Courage and Endurance

MARION J. FABER, R.N.

ALL institutions interested in preparing young women to lead productive and happy lives are constantly giving more scientific and careful thought to the planning of a program designed to produce the highest degree of mental and physical health possible.

Such a program should include, first of all, the best method of choosing the prospective student. It is most important to know something of her ideals, what her system of values is and what her vital interests in life are. She must come to the school with a certificate of good health from her home physician. Shortly after entering the school, she should be given a thorough physical examination by the school physician. If she is found by him to be physically sound, she is immunized against certain diseases with which she is likely to come in contact.

If the prospective student's academic record in high school has been poor, she should be given a mental test, for if she has not the requisite mental ability to carry the academic work prescribed by the school, she should be advised against entering the school. This prerequisite mental ability can be determined by a comparison of her intelligence quotient with established norms obtained from mental tests previously given all the students of the school.

In rejecting a student, a careful study of her personality should be made and constructive advice offered her as to her future career. It might even be possible to coöperate with a vocational guidance bureau and hence give the student the benefit of more expert advice.

One physician connected with a prominent medical school, and much interested in the training of nurses, states that raising academic standards does not reduce the mental hygiene problems of the student nurse. I do not altogether agree with this statement, for I believe that any student who is capable of doing a good quality of academic work without too

[1] Read at the annual meeting of the Nebraska State League of Nursing Education, October, 1928.

much effort on her part, or any student with a reasonably good mental endowment is much more likely to have wider interests, higher ideals and a happier outlook on life than one whose mentality makes her incapable of sustained effort and interest or effective accomplishment in her work. Emotional balance is a most desirable quality for successful nursing but a large vision, a burning enthusiasm, and an indefatigable will, are sometimes needed to revolutionize old ways of thinking. Many geniuses in other walks of life have been erratic and emotionally unstable, but they revolutionized the thinking of their age. Too much leveling of the student personnel, making the students too much according to one pattern, is not to be desired in our profession any more than in other professions and certainly does not foster a spirit of leadership.

The introduction of the student to her new life is a very important part of her first months in the school. She should have all the knowledge possible at her command to maintain and improve her health before she enters upon the heavier responsibilities and duties of her work. Therefore, it is imperative that any handicaps to either physical or mental health be removed as soon as possible after her entrance into the school.

Every school, whether it be a school for nurses or for university students, should plan a definite health program for its students. This plan should include health service which will provide adequate medical and nursing care for students who are ill as well as a definite course in health instruction. In addition to health service and health instruction, there should be a greater or less amount of health supervision throughout the student's training.

The course in which the principles of mental and physical health are studied and discussed should be of great aid to the student in making her adjustment in the school. She should gain from such a course a clear understanding of the relation between health and efficiency. She should realize that "positive health is a worthy aim because it increases pleasure, diminishes pain and is needed for hard work."[2] She should also understand that women, although biologically possessing greater endurance than men, have much greater difficulty in maintaining health; also that health is a growth and needs constant nurture.

Discussion on the part of the students in this course should be encouraged. The student should be invited to come for personal conference and advice. She should take an inventory of her health and check up on her progress in overcoming her bad habits and her handicaps. Weight charts should be kept by the individual members of the class. All who are seriously underweight or overweight and all who suffer from constipation should be given a course of diet-therapy under careful medical supervision.

To make health habits lasting, constant inspiration and encouragement must be given the student. A health habit can only be established on the same psychological principle on which we found any other habit, that of associating one specific type of stimulus with another specific type of stimulus or response. Overstreet[3] says that every human being has certain wants, that everyone craves adventure, travel, leadership, novelty and constructive achievement and that no appeal to reason is effective

[2] Dr. Farrand, President of Cornell University, Address, American Health Congress, Atlantic City, June, 1926.

[3] Overstreet, "Influencing Human Behavior."

that is not also an appeal to a want. The whole difficulty in building an enduring and wholesome attitude in physical and mental health habits is in finding an effective and lasting association to make our health habits endure throughout life. Too often when probation days or college days are over, regular habits of play and recreation disappear.

The student should understand that recreational therapy is an absolute necessity in the life of each one of us and that only as we teach and practise health do we fully do our part as nurses. Extra-curricular activities should be made the basis for enlarging the possibilities of recreation for the young student who still has much to gain from training and education in health habits. One of the greatest values of extra-curricular activities for the student is that it makes her a social human being; it offsets any tendency on her part to be "shut-in"; it means "doing things with people"; it gives the student a hobby which, if enthusiastically pursued, will not only improve her health but make her a good sportswoman. Efficient accomplishment in any good sport tends to prevent the development of an inferiority complex because the individual with such an accomplishment more readily makes a place for herself in the social life of the community.

Another method of building up a lasting association which makes health a habit, is to allow the student during her training to take an active, even though amateurish, part in the teaching of public health. This might be done in several ways, any one of which might succeed or fail in the particular school in which it is tried because the success of such an undertaking depends so largely upon the willingness of a public health expert to give aid and inspiration to the venture.

The teacher of public health in coöperation with various public health organizations might ask the students in her class to assist in health demonstrations. As a part of the work of the Senior year, health talks might be given, first, to the class of which the student is a member, then later to outside groups of adults and school children. Each Senior student in school might also aid in some school inspection, following a carefully supervised plan of instruction. Or a health promotion week might be planned by the Senior students for the entire nursing school. Another suggestion has been made that students might participate in the teaching of classes in home hygiene and care of the sick as a kind of practice teaching course under the supervision of an instructor of recognized ability.

Most of our training schools today realize the value of encouraging the student to use a library as a part of a recreational program. Periodicals, fiction and reference books should all be at hand for the use of the student. Special arrangements may often be made with a near-by public library for the loan and use of books. Also the necessity for adequate study periods is being given greater emphasis in schools of nursing. We take it more or less as a matter of course that required night classes in a nursing school should be the exception rather than the rule, that no nurse student shall work more than eight hours out of twenty-four, that class time shall be included in the eight hours and that there should not be long periods of night duty.

The psychology of fatigue has proved that short periods of rest are much more effective in offsetting the bad effects of fatigue than longer periods of rest. On the basis of such data we conclude that the student will work

more efficiently if, in the middle of the morning, she have fifteen minutes away from the ward for a cup of cocoa or a glass of milk. It has been argued that this would encourage the "no-breakfast" habit. But the value of a short period of relaxation far outweighs any such objection, if it actually exists. A night off duty each week for the nurses on night-duty has also been found most beneficial from the standpoint of efficiency and health.

The environment of many hospital centers is often not pleasing, but an enthusiastic recreational director can with the coöperation of the supervisors on the wards do much to offset such environment by planning "hikes," picnics, other out-of-door amusements and excursions of various kinds at regular intervals.

One reason that it is always possible to do much to inspire the enthusiasm of the probation group is that they are an unbroken group, having the same classes and the same hours off duty. When once they begin eight-hour duty in the hospital, they are scattered and their hours are different. Here again we find a difficult problem of adjustment for the student. The change to eight-hour duty leaves the student so physically fatigued at the end of her day, until she becomes accustomed to the more strenuous physical work, that she loses her enthusiasm for her recently established health program. Also she experiences a certain loneliness, for she finds that there may be no one of her group off duty "to do things with her." At this point and throughout the remainder of the student's three years, there should be most careful planning of her health program by one person whom the school has chosen for that purpose. Each student should be encouraged not to lose her zest for outdoor sports and exercise. She should be urged to continue in the practice of her chosen sport or hobby until she has become efficient enough to enjoy the exercise without undue physical effort. To do this, supervisors on wards must be willing to coöperate with the physical and recreational director in planning the student's time off duty.

Much more careful planning and coöperation are necessary after probation than before, for most of our students are not able to plan even a single day ahead under the present system in the majority of our schools. Many of us have felt, for this reason if for no other, that nurse-schools do not allow the degree of individual freedom that other educational institutions offer.

We realize of course that there must always be considered first and foremost the welfare of the patient. But we believe that it is possible not to neglect the patient's care and yet at the same time plan the student's program so as to give her greater happiness and freedom in her work. The student nurse today is young and immature and we must meet the issue squarely, otherwise the work or the student or both will suffer. It is only normal that wholesome fun and recreation should be a large part of her life.

It has been the policy of most of our training schools to withhold any advance knowledge of our plans from the student. Also any great interest displayed on the part of the student as to whether she was to come off night duty or go on night duty or afternoon duty was frowned upon and considered unethical conduct on her part. Any student who might have a definite reason for requesting a specified time off duty occasionally was looked upon as bothersome and lacking in interest in her work as a nurse. Such an

attitude on our part seems to me to be dangerously lacking in sympathy and understanding of the student's view-point. The result is repressions and conflict, for the student cannot have her fun when she has the opportunity and the result is a smouldering resentment, either personal, or against work and training, which robs her of her rightful youthful enjoyment. It is only normal that a healthy, young individual should have many interests besides those within the four walls of the hospital. If we wish to foster a wholesome physical and mental life in our students, we shall have to be more human ourselves and not mere machines for efficient service.

Many of the more obvious facts of mental and physical health have been given consideration in our discussion. Let us now turn to the less obvious aspect of this problem. We know that the serious and immediate dangers of life and health are always cared for first. Usually the environment is then improved. The eight-hour day has made the work of every industry and profession much more desirable. The public conscience, in such matters as these, is demonstrated by its efforts at legislation in behalf of many measures which give to the working man more of the comforts and good things in life. Our profession has been one of the last to see the necessity of an eight-hour day and to give scientific consideration to the psychological effect of fatigue on efficiency and accomplishment of work.

The newer aspect of the improvement of health and happiness is to approach the problem from within. The individual must seek to understand his relation to his environment, to understand how to control and change certain elements of that environment to his advantage or how change himself so as to change the relationship to his advantage.

We realize, more and more, that physical and social health are interdependent and that the individual who withdraws from reality tends to build up an artificial phantasy, world of his own, that social health means the ability to get on with one's fellow men.

We realize that not only do physical and chemical factors cause ill-health but often there are psychic factors which are much more powerful influences in producing ill-health than either of the other factors. Nurse students must be given an insight into some of these psychic factors to understand many of the peculiar behavior reactions in their own lives. They must understand that hysteria and neurasthenia are social diseases which are caused by the maladjustment of the individual to his environment; that such diseases are a sort of psychological defense reaction, hiding the real cause of the trouble, and that such reactions are expressions of a psychic difficulty in terms of body-reaction.

One prominent psychiatrist even goes so far as to say that the medical profession now recognizes that an emotional upset may bring about nausea, vomiting, weakness, chills and headache. These manifestations, the student should understand, are often merely protests on the part of the individual against life as it must be faced. Migraine headaches are now thought by many physicians to be wholly psychic in origin, the outcome of an emotional conflict. If the student can have presented to her such theories as Adler's in which he sets forth the idea that many of the maladjustments of life resulting in various forms of psychic conflict are due in the first analysis to some organ inferiority; or if we present Freud's view that conflicts and complexes are

due to the repression of desires which are socially unacceptable, will not the student have a better insight into all her own problems and attempts at adjustment? Will she not be able to understand better some of the causes of mental unhappiness in her own life and those of her friends?

The protected home life of some of our students, some of them pampered at home, often causes much suffering when the realities of life have to be faced among people who do not make allowances for bad nerves or temper fits as the fond mother or aunts were accustomed to do at home. Often for the first time in her life, the student must recognize and have others recognize her faults and shortcomings and strive not to be over-sensitive to criticism. She must learn to profit by her mistakes instead of covering them up or rationalizing about them.

She should be led to see that a sense of humor is an indispensable ingredient of a pleasing personality, that a humorous person is interesting because he is not predictable, not priggish, not a fanatic; also that things straighten out far more quickly in the presence of the genial and understanding mind than in the presence of the mind all ugly to condemn and crucify, that the most liberating ability we possess is the ability to laugh at ourselves.

The student should also gain the conviction from us that there is the need for a certain degree and quality of unselfishness in our relations with others, that a spirit of service is requisite for success in any profession but peculiarly so in our profession because nursing is a work of service.

The course in mental hygiene should embody a frank, wholesome, scientific discussion of sex matters, leaving with our students an understanding that an abnormal reaction in sex problems, just as in any other problems, leads to repression and conflict, whereas a normal solution is some form of sublimation.

Our students should also understand that such emotions as hatred, fear and jealousy, from both the psychological and physiological standpoint, are destructive to the organism; that fits of blues, morbidness, unsociability, sudden and unaccountable changes of mood and extreme timidity are all unhealthy mental reactions and must be overcome and guarded against as enemies.

The student should have brought clearly to her understanding that there are certain glandular and circulatory changes in the body during menstruation which may be the cause of an otherwise puzzling tendency toward depression or hilarity at this time; that during the menstrual period a little less food, a little more self-control, a little more sleep and a moderate amount of exercise in the open air will do much to relieve and offset the psychical and physical symptoms often occurring at this time.

The student should learn to know herself, accept herself, and be herself and to realize that to attain to true mental and physical health, she must give up all sham and pretense, in order to avoid the formation of undesirable traits of character.

If the student can thus early in her course be given an insight into the various behavior mechanisms, she should be able to avoid tendencies to morbid indecision or too ready despair and realize that abnormal reactions breed discontent and discouragement, make one weary, bitter and drab-minded. She will see that a normal individual should be able to make rapid, mental adjustments, think clearly, make firm decisions and keep her emotions well under control.

The student should also see that we are now taking a broader view of the whole sick individual and that we do not any longer center our interest on only one part or organ of the body.

If the student can be led to accept herself, having honestly understood her limitations, with no feeling of inferiority, a happier more normal individual will result.

The student should in the last analysis understand that body is not everything, that mind controls the body in all its reactions to environment.

Investments as a Therapeutic Measure

ONE hospital has found that inducing people to invest, in however small amounts, is a very good means of bringing back the urge for life sometimes lost during illness. One nurse patient had been in bed two years, and had lost all desire to get up. She said frankly that she was quite comfortable, that she feared further breakdowns if she tried to be active once more, and that she would be quite content to stay in bed for the rest of her life. In bed she was getting regular food, good care, and had no worries. Her nurse decided that some great incentive for living would be necessary to overcome this demoralization, so she collected considerable literature on building and loan funds, showing the results of regular investments which should mature after not too long a time, and return to the investor a tidy sum representing the payments, plus a good rate of interest—something like $1,500 at the end of ten years of laying aside only ten dollars a month, for instance. The definite sum and the prospect of being independent, so inspired the patient that she immediately began payments out of the small allowance sent her from home. Before a very long time, she was so improved physically that she was up and around. Shortly she became interested in other investments, and began putting more money saved into them. Her progress in health continued steadily until she was able to go on duty. Nowadays she can hardly be induced to stay off duty a day. Her investments are growing, and she is once more a useful member of society. What would have happened to her without the stimulation of the interest and well-being instilled by being able to watch her money grow larger through systematic saving?

This same real nurse had someone employed about her hospital whom she induced to put $10 a month in building and loan investments, out of a total wage of $25. When his younger brother wanted to come to this country, he was able to borrow at the bank on this investment enough money to finance the passage and provide the amount needed to pass the immigration authorities. The younger brother paid the amount back out of his earnings after admission to this country. When the War came on, the older brother had developed such a sense of responsibility that he could be advanced rapidly in his work. He is now married, with two children, a house, and a good salary as supervisor of a department. Without that initial incentive, where would he be?

Another experience of this same nurse is of one of her patients who was dissatisfied with life, and practically an anarchist, ready to wreck the whole country. Life was of very little interest, and he would have been quite content to die. The nurse surrounded him with people who were making small investments in reliable stocks or bonds, and watching the market eagerly to see whether stocks went up or down. The patient became fascinated with this, decided to have some of the fun himself, invested slowly, and finally became worried at the slightest suggestion that the government might be overthrown, or anything happen to the established order which was keeping stocks up.

Stocks, where they are safe, Building and Loan in states where they are trustworthy, bonds through a good house, all make people save money. A thousand dollar bond may be bought in instalments, with a small first payment, and the desire to own the bond completely stimulates saving. By always owing something on a bond, one will not squander one's money. With these investments one will have some connection with a bank, and have the benefit and advice of the bank in any doubtful matter.

Nothing is so conducive to self-respect and good citizenship, and through that to good health, mental and physical, springing from peace of mind, as definite investments, and a knowledge that one has resources for a rainy day. Most of us think we can do so little that it is not worth while to do anything at all, but everyone could do without a few "movies" or sodas, and save $10 a month, no matter how small a stipend she receives. With intelligent savings, this would amount in a few years to a tidy sum, and she would be much more happy, and so more useful.—Sent in through Nina D. Gage, December, 1928.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Christmas Messages from Far and Near

TO the office of the National Director of the Red Cross Nursing Service, from far and near, Christmas messages and gifts came fluttering in for many days in advance of that blessed day. It was a real joy to open these greetings, for nothing brings greater pleasure than these messages of affection and good-will from the loyal daughters of the Red Cross. I would like to write a letter of acknowledgment to each one, but as this does not seem possible, may I take advantage of the facilities offered through our beloved "green journal" of thanking each and every one for thinking of me and of our Red Cross and, like Tiny Tim of immortal fame, say with him, "God bless us, every one."

Special Actions of National Committee on Red Cross Nursing

AT a meeting of the National Committee on Red Cross Nursing Service, held on December 11, in addition to interesting reports presented by the service heads of the Red Cross, Judge Payne reported upon the proceedings of the Thirteenth International Red Cross Conference. He informed the National Committee that, as a result of the entente established at the Hague, a single National Red Cross made up of Red Cross Societies of various nations, the International Committee of the Red Cross, which functions primarily in relation to war and the League of Red Cross Societies, which devotes itself exclusively to the services of peace, now exists.

Considerable time was spent on the discussion of disaster nursing. Miss Fox gave her experiences in Florida, and Miss Havey in Porto Rico, while Dr. DeKleine, the recently appointed Director of Medical Service of the Red Cross, spoke briefly upon his conception of Red Cross responsibilities during a disaster. Among other points that he emphasized was that "the nursing service should always be under the supervision of the Red Cross, *i. e.*, if the Red Cross is in control, and directed by a Red Cross nurse." This does not mean that local nurses, whether enrolled or not, will not be used.

Major Julia C. Stimson announced that the new nurses' quarters at the Walter Reed General Hospital would be called "Jane A. Delano Hall," in memory of Miss Delano, who was one of the early superintendents of the Army Nurse Corps.

Both Miss Bowman and Major Stimson reported vacancies in their respective Nurse Corps (Navy and Army), and urged that the Red Cross assist in every possible way in bringing this fact to the attention of the nurses at large. While the salaries paid in these services is not at present as attractive as those paid in civilian institutions there are, however, compensations of a rather unusual character that offset this. For full information regarding these services application should be made direct to either the Superintendent of the Army or Navy Nurse Corps, Washington, D. C.

The Navy, particularly, desires nurses who have had some executive and teaching experience, inasmuch as the nurses of that corps are responsible for the instruction of the corpsmen in nursing procedures. As the report of the Committee on Grading shows that, except under extraordinary circumstances, there is an over-supply of nurses in the private duty field and that many nurses are for months without work, we would like to commend to the consideration of those especially qualified the opportunities in government nursing services.

Mrs. Mary A. Hickey, the Superintendent of the Veterans' Bureau Nursing Service, stated that 1,940 nurses were engaged in that service, and that only fifteen vacancies existed. She also reported that, on January 1, 1929, the pre-educational requirements would be raised to four years' high school. As the nurses for both this service and the U. S. Public Health Service are under Civil Service, it is felt that a great step forward has been taken when that department places its pre-educational requirements upon so high a plane.

Lucy Minnigerode, the Superintendent of Nurses of the U. S. Public Health Service, reported that 390 nurses were on duty and that practically no vacancies existed, but that when the new hospitals which are under construction are opened, additional nurses will be needed.

Elinor Gregg, Director of Nursing Service of the Indian Bureau, presented a very interesting report of her service. Miss Gregg has been newly appointed as a member of the National Committee on the same status as the directors of other Government Nursing Services.

There was considerable interest displayed in the methods now employed of increasing the enrollment. Jane A. Delano Recruiting Week, it was agreed, offered one of the most satisfactory methods in this connection.

The Committee was asked to decide the question: "How far the responsibility of the Red Cross should extend in following up the annual membership of enrolled nurses in Alumnae, District, State and American Nurses' Association?" The Committee was of the opinion that it was not the responsibility of the Red Cross Nursing Service to follow up the annual membership of Red Cross nurses in the American Nurses' Association. It was agreed that having determined at the outset that an applicant for enrollment was a member, it might take for granted that she would continue this membership without further advice from the Red Cross.

The increasing demand for the assistance of Red Cross nurses in full uniform in public demonstrations of all types was brought to the attention of the Committee. Several instances of what seemed like exploitation were cited. After some discussion a resolution to the effect that the National Committee discourage the use of Red Cross uniforms for purely spectacular purposes was unanimously approved.

A very interesting report on the "Service to Sick Nurses" rendered by the New York County and Bronx Chapter was given by Florence M. Johnson. So much good has been accomplished by this particular type of service, to which the full time of two nurses and part time of a third is given, it would seem quite practical if similar work were undertaken by other metropolitan chapters.

Alta Dines, reporting on the Nurses' Convalescent House at Babylon, Long Island, stated that in the four years since its organization 1,199 nurses have been received. The average stay is three weeks.

The suggestion having been received that the annual address questionnaire be sent every two years, instead of every year, to those nurses who indicated that they were inactive, called out some discussion. It was unanimously decided, however, that the questionnaire should be sent annually to every nurse in both the general and Home Defense enrollment.

The Nursing Service statistics included certain interesting figures; for example, the total enrollment on July 1, 1928, was 47,252; 197 committees on Red Cross Nursing Service were functioning on that date, upon which approximately 1,300 Red Cross nurses were serving as volunteers; 2,010 nurses were enrolled during the fiscal year. Out of the total number of enrollments, 14,791 have married and are, therefore, on inactive status; 1,629 have died. There are 1,632 nurses in the special enrollment group. The total number of address questionnaires which were returned by Red Cross in 1927 was 24,105. If this number can be accepted as an index of those who might be available for service in a great national calamity, such as war, it is conclusive proof that the enrollment of young nurses should be stimulated to the fullest extent.

Preparations for Combating Influenza

A SPECIAL COMMITTEE was appointed at National Headquarters, of which Dr. DeKleine, the newly appointed Medical Director, is the chairman, to study ways and means of assisting in the influenza epidemic, should it assume such proportions that Red Cross participation is requested. A letter was sent to the chairmen of all the chapters from the Vice Chairman of Domestic Operations, suggesting preparatory measures, together with a special statement on the influenza situation from Dr. DeKleine. The latter had been prepared in coöperation with the Surgeon General of the U. S. Public Health Service. Copies of these were also sent to all the Local Committees on Red Cross Nursing Service in the United States by the Chairman, urging them to be prepared to assist should nurses be required. Response from the committees has as usual been prompt and coöperative. So far, there has been very little need of Red Cross assistance, but as one of its charter requirements is "that it shall render aid in time of national disaster caused by pestilence," it stands ready to assist should calls be made upon it.

Instructions for Supervising Nurses in Disasters

A REVISION of the "Instructions for Supervising Nurses in Disaster," which were prepared by Olive Chapman some years ago, has been made by Miss Fox, in the light of her experience. These were presented to the Nursing Field representatives at the Field Staff Conference, which convened in Washington on January 3, for suggestions. With the increasing demand being made upon the Red Cross for assistance in all types of disasters, it became necessary to arm our Field Staff with a manual on procedures and policies, as applied to the Nursing Service. The "Instructions to the Committees on the Selection of Nurses for Disaster" will also be made the subject of revision.

The three big disasters to which supervising nurses have been assigned, *i. e.*, Porto Rico and Florida, and the epidemic of typhoid at Olean, N. Y., have gradually brought their nursing programs to a close. Miranda Bradley succeeded Miss Havey in Porto Rico. She, however, returned

to the United States late in December, when all nursing activities were assumed by the local health and nursing groups. Ruth Mettinger, who succeeded Miss Fox in Florida, in making her final report states that 27 Red Cross nurses were on duty as volunteers and 30 were paid. Practically as many more who were not enrolled, including some practical nurses, also served in this connection, making a total number of nurses and others used for nursing work—93. The type of work extended from emergency hospitals, assisting in private hospitals, first aid dressing stations, and inoculation stations to follow-up public health work, camps, etc. Miss Mettinger has submitted, as a result of her experience, some very practical suggestions which, if utilized, will unquestionably prove of great value to those who are called upon to assist in these great emergencies.

The final report of Mrs. Heilman, who directed the nursing work at the typhoid epidemic in Olean, N. Y., states that on December 20 there were still thirteen nurses on duty. The public press has carried such full and complete reports of the number of cases, and number of nurses used, etc., that further details will not be included.

Special Instructions to Committees

THE letters which have been sent to the Committees on Red Cross Nursing Service, one covering the details of the Delano Recruiting Week, and the other dealing with the American Nurses' Memorial, have accentuated in the former instance the importance of good local organization, which includes the Local Committee on Red Cross Nursing Service, Graduate Nurses' Association, local League of Nursing Education, the Red Cross Chapter and other interested groups, as the first requirement in order to make this activity a real success. March 12, Miss Delano's birthday, should be used as the date for the culmination of such programs as the local groups may develop. It has been suggested that where a large rally was held last year, it might be well to adopt this year some simpler form of memorializing the day. The Local Red Cross Committees are urged to support the District Societies and other groups of nurses who may be working for the American Nurses' Memorial, in developing a local program for raising the state quotas.

New Appointments

WITH the resignation of Matilda Harris as the Assistant National Director of Nursing Service, Pacific Branch Office, Rena Haig, who has been Assistant National Director of Instruction in Home Hygiene and Care of the Sick Service for the Midwestern Branch Office, has been appointed to succeed her. Miss Haig carries with her many years of experience in various types of Red Cross work. We bespeak for her from the nurses of the Pacific Coast the same type of loyal support that they have accorded to her predecessors.

Pansy V. Besom has been appointed to succeed Erna Kuhn as Director of Nursing Service for the Manila Chapter of the American Red Cross. She thus begins another three years with that organization after an interval of three years in this country. Miss Besom sailed early in January for her post.

Student Nurses' Page

Senior Nurses' Experience

As Assistants to the Instructor in Nursing Principles and Practice

M. HELENA MACLEAN, MARJORY MACLEAN AND VEDA LOHNES

Massachusetts General Hospital Training School for Nurses

Arrival.—In February a class of forty-eight preliminary students began their course at the Massachusetts General Hospital. We three Senior nurses had been chosen to assist the Instructor in Nursing during the ensuing term. You can imagine how excited we were in looking forward to such a new experience; and how thrilling it was to see these girls, who were to be "our" students, arrive. How well we could picture just what their thoughts were and how their arrival brought back to us our own feeling on a similar day, two and one-half years previous.

First Class and Initial Preparations.—The first evening they were welcomed by the principal of the school, and the following morning all assembled in the classroom for roll call and inspection of uniforms. This year, we are glad to say, the uniforms were uniform, for they had been purchased from the same concern and made according to submitted regulations. A few collars did ride up under chins and apron and cuff studs were sometimes used interchangeably. Thus began the first day of their eventful and fateful career as probationers. They were not the only ones feeling the novelty of their positions, for we felt almost as awkward as they, adapting ourselve to our new responsibilities.

Conferences of Assistants.—The following morning we had the first morning conference with the instructor, in regard to the course and our duties. Later we learned that these conferences were the high lights of our day.

Ward Assignments.—The class was divided into three sections so that more individual attention might be given. One supervisor was placed in charge of each section. The first day consisted of classes only, but the following day ward assignments were made.

Assistants' Duties.—Special duties were rotated weekly and changed every third Monday morning. These special duties included: roll call, supervision of study hour, and the care of the classroom.

Roll Call.—At 6.50 every morning, excepting Sundays and holidays, all students reported at the classroom where attendance was taken by the assistant in charge of roll call, and the cause of absence or tardiness investigated. After breakfast, the same assistant made a tour of the wards to request the head nurses to save such nursing procedures as were needed

that day for the practice experience of the preliminary students.

Study Hour.—At 7.20 every morning, all students assembled in the classroom for one hour of study. During these periods the assistant in charge of study hour answered questions and gave any advice needed.

Care of Classroom.—The assistant in charge of the classroom was responsible for orderly management of classrooms, for daily and weekly supplies, the assembling of equipment for demonstrations, and appointment of proctors. This was, perhaps, the hardest duty of all, as it required a keen eye to see and a keen mind to remember all things necessary for demonstration and practice. We experienced many moments of fear and doubt when we realized that something was forgotten.

Compulsory Study Hour.—The students' study programs were arranged by the Instructor in Theory, and the time not spent in the classroom was converted into practice on the ward. There was a compulsory study hour, one hour and a half, for the first four evenings of the week, proctored by the student assistant.

Correlation.—Correlation between practice and theory was of prime importance. We taught fracture beds when the skeleton was the subject in anatomy; application of heat and cold when the circulatory system was studied; and catheterization in our classroom was concurrent with the teaching of the urinary system in the other classroom.

Demonstration Period.—Approximately thirty-six demonstrations were given during the course. Of these we each did our share, with the instructor, or alone, under her guidance, and thereby gained wonderful experience. The subject matter of each assignment included words and definitions of which the students took charge. It was very interesting to see with what enthusiasm they responded when one of their own class was on the platform. As often as time allowed, during their period, a student presented a case study which was worked up entirely by herself. Each case was related to the lesson given. Fifteen minutes of the period was devoted to a written quiz—these consisting of twenty-five questions of various types—true and false, mixed, analogous, and various other types. Once a month a test was given covering that month's work.

Practice Period.—Two or three times, each week, every section had a three-hour period of nursing practice in the classroom. Here, every student was under the direct supervision of the instructor or the assistant in charge of that section. To stimulate interest, a half-hour oral quiz was held at the beginning of the period. Each student announced her demonstration, gave diagnosis of the supposed patient, signs and symptoms of the disease, treatment, and effects expected. They then supervised one another's work. To do this more efficiently, score cards were used for rating:

Safety and comfort of patient	18
Neatness and finish	13, etc.

with a total score of 100. On the back of the card they recorded their criticisms of the work. These criticisms were discussed by the students and instructors at the close of the period. In the second month a time-table was drawn on the blackboard to stimulate speed in their work. The headings were:

Student's name
Demonstration
Time allowed
Time finished
Gain or loss

The sum total of gain or loss of each section was recorded on the bulletin board from day to day. This was in charge of an appointed time-keeper from the class. Such rivalry and excitement, as first one section and then another was in the lead!

Classroom and Ward Correlation.—Correlation was also carried out between classroom and ward. As each demonstration was completed in the classroom, it was then practised on the ward under individual supervision. To inspire enthusiasm and more coöperation between student and head nurse, score cards were given each probationer. On these were listed the completed procedures which were rated by the head nurse and the students themselves, if unsupervised. In order to inspire competition, a monthly average of these nursing procedure score cards was made and the leaders in each procedure posted. For those who were backward and lacked initiative, assignments of special work were made to be completed in a definite period of time. (Days, or weeks, as the case might be.)

Ward Work and Experience.—Our ward work was where we found our greatest field for practical instruction. Some were quick and alert and adapted themselves remarkably well, while a few proved discouraging. Their eagerness to try new procedures and accomplish greater experience was marked. Many of the students came on duty early, of their own accord, to obtain experience which was not available in their short periods on duty. With our permission, students were allowed to go to other wards at any time for anything of interest, such as group clinics where nursing treatment is discussed.

Weekly Records.—It was our duty and also the head nurse's to alternate in writing weekly reports of each student under her care. These contained concise facts and careful observations in regard to intelligence, reliability, technical skill and personal traits. These reports were given to the instructor and discussed at conference. Later they were given to the principal of the Training School.

Section Rotations.—Each month, too, we changed sections. Thus the student in charge of Section One, the first month, had Section Three the third month, while for the last month she came back to her original section. How interesting it was to have your own section of students back again, and see just how much progress had been made!

Duty Hours.—Off duty meant 4.30 each day except one; when they remained on duty until 6 for evening care of patients (having previously had two hours off duty during the day). Saturday was always welcome for it brought our afternoon off duty. The Sunday schedule rotated—one section had all day off, another worked from 7.30 to 12.30, and the third from 1 to 6. On holidays, each section worked one-half day. This schedule applied to us, as well, with the exception that in our turn, holidays meant "all day off."

Monthly Examinations.—Once a month a practical examination was held. As usual, the student presented her subject before beginning her demonstration; from there on it was a silent demonstration. Errors were recorded on paper and discussed with the students individually afterwards. One month the students were allowed to take charge of the practical examination, selecting their demonstrations, while the instructor and we were "visitors." The third month before the written examination was taken, they were told that those making 80 per cent or over would be excused

from the final written examination, and—they strove!

Of course, the biggest day of all was Public Demonstration given at the end of the four months' course. Then the house officers, head nurses and as many visitors as wished were allowed to come and to watch everything from a bed bath to cupping. You may be sure that they were a happy group of students when that day was over. How many of us, as nurses, will ever forget our own "Final Demonstration"?

Conclusion.—And what shall we say in closing? It has been a wonderful experience, the value of which we are going to appreciate more and more as time goes on, not only in teaching, but in whatever else we do. A busy four months? Yes, but one of the richest four months we have ever had; while, of course, we think this class the very best that has ever entered the school!

General Conclusions on High Heels

1. Many thickenings and calluses not previously observed have been noted at the back of the heel since spike heels have been worn. In a few cases it was found that the heel tendon had contracted and the wearing of low heels caused discomfort or pain.

2. The large number of lowered anterior arches would seem to indicate that even the wearing of spike heels for dress occasions may be followed by damage to these arches.

3. Backache is likely to be increased by the wearing of high heels.

4. The danger of injuries from falls is unquestionably greater in high heels.

5. Fatigue, irritability and nervous conditions appeared to be associated with the wearing of high heels.

6. Dysmenorrhea seemed to be increased in those who wore high heels more than half the time and probably in many who wore high heels only for dress occasions.—From "Are High Heels Injurious?" by S. Elizabeth Van Duyne, in *Hygeia* for January, 1929.

Nursing in Ecuador

SINCE Ecuador is so backward in everything else, it is not surprising that it is backward in regard to hygiene and sanitation. All of the best doctors go away to study, and it is to their credit that they arouse the people as best they can, but with little effect. Cases of leprosy and bubonic plague are isolated; but there is no quarantine law, so other diseases are easily spread. We have everything except yellow fever and certain African and Asiatic fevers. The common people seldom call a doctor until it is too late, after trying all the herbs and patent medicines they know. The Indians have witch doctors who are always busy. The common people divide diseases into "hot" and "cold." Medicines are divided the same way, and woe to the man who takes a "hot" remedy to cure a "cold" disease! It is very difficult to get people to eat proper food. Rice is a staple; just recently a whole family came down with beriberi. They raise vegetables and fruits but rarely eat them. The poor people seldom buy milk oftener than once a week. It is hard to convince them that we eat vegetables for our bodies' sakes and not from "custom." In the coast region, hook-worm disease and malarial fevers abound. Other parasites are common, also. One summer I spent a great deal of time giving various remedies hypodermically to those who could not afford to go to a doctor. The problems are multitudinous. I am here as a missionary, so I do not go into homes on private duty. I fear that no family would allow me to follow the methods I have been taught. Among the Indian population I have gone about much as the district nurses at home do, except that I seldom have the advice of a doctor. Usually they offer no resistance to any plan of mine, and I thoroughly enjoy that work. The Indian is mortally afraid of a white doctor, but has learned to trust the missionary. As I go in among the "Head-hunting Indians" I shall no doubt meet many new problems. I have been told that their chief ailments are digestive disturbances and skin diseases, though recently an epidemic of measles caused many deaths. Snake bites are very common, as well as accidents of all sorts. I feel quite unequal to all the responsibility that will be mine. Now and then I am called upon to care for a sick missionary. As I truly love my profession, this is always considered a privilege.

A. T. A.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

Heartless Nurses

I RECEIVED word that my brother's name was on the danger list and went in at once. Although the head nurse knew I was a nurse and his nearest relative, she gave me only the interne's name when I asked for his doctor and when, discovering this, I waited by his side a whole forenoon for the chance to see the head doctor, not a doctor of any kind came near him. In the five days he lived I never succeeded in obtaining any accurate information as to his condition. The head nurse either knew nothing or would tell me nothing, and it was about the same in the case of the interne. When an X-ray was taken, I asked the head nurse how it came out and she said she did not know, that was the doctor's business, which matter alone shows how much real interest she took in the patients under her care. And yet she found time to fold blankets in the linen room, her occupation when I asked the question.

Never have I seen any patient receive less nursing care. He would have received more had he been in the poorest home. He was not the complaining kind and said little about his treatment, but he did tell me (we all know a pneumonia patient's strength should be saved in every way) that the orderly made him raise himself on the bedpan and left him on it so long he could not stand it, finally succeeding in getting someone to come who left the pan on a chair close by, because it was not his business to attend to it! The night before he died, the tray brought to him at supper time had on it a hearty dinner such as one might expect a day-laborer to eat, and to this he was expected to help himself. In fact, he seems to have been expected to care for himself in every way. The morning I spent with him there was a basin of water on the table beside him, containing a small piece of soap and a washcloth. Evidently he had been doing his own washing. A mincing little nurse in stiff white apron and cap was told to take it away, while the head nurse removed bathrobe and slippers, for it would not do to have the room untidy, but the young nurse just took the soap out of the water, squeezed the cloth and put it at the head of the bed before removing the basin, nor did the head nurse say a word as to her methods.

The night before my brother died I was much worried about him. He looked very bad to me and I hated to leave him. Had I been in touch with him all the time, as were the nurses and doctors at the hospital, or as they should have been, I should have known he was distinctly worse. Of that I am sure. Had they only told me that much when I asked for some definite word about his condition, I should not have left him. But the head nurse said, "Oh, it has been a warm day, and I think all the patients have felt it," and the interne spoke of another two or three days. No notice of any change would be sent me, but as I could not stay up nights and do my work days, unless the matter were urgent, I reluctantly went home. The next morning I received this kindly (?) telegram: "Mr. ——— is dead at ——— Hospital." If anyone can conceive of a more heartless piece of business from beginning to end, I cannot. My doctor said that the matter should be brought to the attention of the hospital authorities. I wrote, and received in response word that they cared for so many thousand patients a year, the implication being that more could not be expected of them. Probably they think, as does one hospital superintendent with whom I am acquainted, that it takes too much time to show interest and sympathy. And yet interest and sympathy are some of the few things that, fortunately, require no time for expression, that are merely a matter of heart and consequent manner and speech, things essential to every doctor and nurse. Had the nurses been rushed, I should not have thought quite so much of their manner and lack of attention, but they moved about as if their only duties were to straighten beds and bring and remove trays. If they look upon it all as a mere matter of business, it seems to me to be very poor economy to serve a full dinner to a man who can take only liquids. Any fighting chance my brother had, I consider was taken from him by the absolute lack of nursing care.

A friend who spoke of having a similar experience to mine lost a young daughter at another hospital, and her husband was given the impression the night before that there was

no immediate danger, with the result that neither of them was with her at the end. Such things are hard to forgive and forget, and they are absolutely unnecessary, and yet these instances I have given are only a few of what might be mentioned.

Massachusetts. A. F., R.N.

A Nurses' Club Banquet

ON November 10, 1928, the eighth annual Nurses' Club banquet of the University of Washington Department of Nursing Education was held, on the evening following the big home-coming football game. This event of home-coming we look forward to as one of the happiest times of the year. It brings old friends back to the scenes of undergraduate days and inspires the students by the success of those who have gone ahead. Preparation for the banquet is in charge of the students through their Nurses' Club. Various committees attend to the addressing and mailing of invitations, the location and choice of menu for the banquet, the tinting and arrangement of the place cards, and the program for the evening. Frequently the banquet is held on the campus, but this year it was held down town, and we had the advantage of an orchestra while we ate.

We are very proud of the place card. It is the figure of a nurse in student's uniform, drawn by one of our own girls. We have a quantity of these printed, and do the tinting of the figure and the lettering of the name ourselves. When the card is folded to stand up, the upper half of our nurse is silhouetted. During the dinner there are musical numbers from talented members of our group, and songs in which all of us join.

The president of the Nurses' Club presides as toastmistress, and introduces the speakers. There are toasts from members of each of these groups: students, graduate students, alumnae, hospitals, and public health nurses.

The principal speakers this year were Elnora Thomson who came from Oregon for the occasion, and our own Mrs. Soule. If, sometimes, in the classroom we seem to be all brain, and in the wards, all body, here there is held before us the soul of nursing.

In concluding the program, Mrs. Soule asked the members of each class to rise, beginning with 1921, and ending with the Freshmen of the five-year course who will finish in 1933. Each class was well represented, for many had come a considerable distance, and others who were across the continent had written or telegraphed. Then, as loyal "alums" and students, we finished by singing our Alma Mater: "All hail, O Washington!"

Washington. R. M. B.

Treatment of Burns

AS a subscriber to the *American Journal of Nursing*, employed at a Bureau of Nursing Service, I thought it would be of interest to the *Journal* office to know that the article on the "Treatment of Burns," in the September issue, has attracted the attention of several of the local physicians. Doctors have personally visited our office and expressed their interest in the article, and asked permission to take the *Journal* out. The foregoing we feel adds professional prestige to our profession, as well as to our pride in our national publication.

California. E. J.

Information Wanted

INFORMATION wanted of Lelia Kerr (formerly Lelia Johnson of the Johnson family of Gravesend, Brooklyn, N. Y.) who was a student nurse at the Newark, New Jersey, Hospital, in July, 1916.—JAMES J. DUNN, Attorney-at-law, 135 Broadway, Manhattan, N. Y.

Journals Wanted

THE Western Pennsylvania Hospital, Pittsburgh, Pa., wishes to secure the following copies of the *Journal:* 1909, April, May, July; 1911, September, October, November; 1912, February, March, May, June, August, October through December; 1913, January; 1916, January; 1917, May, July; 1919, April, May, July.

The Universum Book Export Company wishes to purchase volumes 1–27 of the *Journal*. Address Bonar Souchay, Secretary, 152 West 42nd Street, New York.

Questions

Please advise me concerning the following questions through the Journal.

1. What should be the age, education, experience and salary of an assistant superintendent of nurses?
2. Of an instructor?
3. Of a night supervisor?
4. What is the relative position of the night supervisor to the assistant superintendent of nurses? To the instructors?
5. What moral responsibilities have the above to the student body?

Answer.—1. The age depends on the individual, but probably a person younger than the late twenties would not have the requisite experience of life and her profession to meet the problems which arise.

As to education, she should be equipped to teach, and to handle the problems of a school in the absence of the superintendent. She would need to have had courses and experience in hospital and school administration as well as teaching. To do her best work the assistant superintendent needs a thorough academic foundation (at least full high school) for her professional course, and then postgraduate work after the school of nursing, and then experience. Postgraduate work without practical experience of administration and teaching as head nurse, etc., will not bring the best results, as the student is not ready to appreciate it.

Salaries vary in different parts of the country, according to expenses of living. It is difficult to give suggestions suitable for all localities. Salaries should be comparable to those paid teachers, and the cost of the previous preparation required for the position should be considered.

2. Instructors need as much educational preparation as does the assistant superintendent of nurses, including courses in education. They do not need so much administrative experience, nor the preparatory courses for that. Their salaries should, in general, follow the limits for other teachers in their localities.

3. Night supervisors need about the same preparation as does the assistant superintendent of nurses. They should realize that though they do not have formal classes, they are teachers, and they must teach by the most valuable method, clinical contact, the young student and graduate nurses who are on night duty. They can often teach the patient, too. Unless they have the educational viewpoint, they will fail to have the influence they should have throughout their work.

4. The night supervisor should be the night assistant superintendent for the school, and of equal rank with the assistant superintendent. It takes coöperation to succeed, but both have equal responsibilities of administration and care of patients, though the night supervisor may not have as many formal classes.

5. Moral responsibilities to the student body are protection, in the emergencies of hospital life, of health and morale; providing the instruction for which the students come to the school; home care *in loco parentis* for girls just leaving adolescence; and also providing a good example of professional conduct, by the staff, in doing their best for the patients, physically, mentally, spiritually, in present and future illness.

A recent lecturer advanced the theory that syphilis may not be transmitted from the parent to the child, but that it is contracted by the child after birth. *Is there any authority for the statement that syphilis is not transmissible from parent to offspring?*

Answer.—"There is no authority for such a statement, and it is thoroughly established that syphilis is transmissible from the mother to the child *in utero*. It is quite true that syphilis may be contracted by the child after birth. This, however, is not *congenital* syphilis, but *acquired* syphilis."

The constitution of our District Association reads: "The object of this Association shall be to establish and maintain standards among nurses, to establish a central directory for nurses, and to support and defend the law relative to nurses, and to promote the educational and social standing of the nursing profession in the State." *How then can superintendents of nurses and hospitals, who are members of the Association, refuse to comply with the rules of our Directory, oppose it, and defy the whole Association with the assurance of*

their absolute authority? Are they not thus opposing the constitution of our Association and rendering themselves subject to censure? What can we expect from nurses trained under superintendents who are so disloyal to the constitution of their Association?

Answer.—The question is a much more profound one than appears from superficial reading. To place blind faith in legislation is to ignore human nature. The mere placing of a law on the statutes of a nation or a state, or a nursing organization, does not mean that the law becomes automatically operative. Even when machinery is set up for inflicting punishment for infractions of the law, there is evidence that unless the law is substantially in agreement with the thinking of a majority of those affected, enforcement will be difficult.

To be specific, the history of central registries would indicate that success has come only in those places where great patience and tolerance have been exercised and when those in authority have striven in a generous spirit to bring representatives of all interested groups into the councils at which organizations and policies were discussed. Arbitrary rulings are worse than useless, they are distinctly harmful. Action, to be successful, must be based on the carefully considered opinions of all concerned. In the case of a central registry, these could be private duty nurses, administrators of hospital nursing services, public health nurses, the medical profession, and, by no means least, the laity.

This process of education, for that is what it is, is a slow one. But it is the only sound one, if the history of our organizations means anything. It is dependent for success on leadership by wise, tolerant, well-informed people who have the patience to see beyond immediate difficulties to the larger goals of truly coöperative effort.

It is difficult to believe that superintendents of nurses would oppose the rulings of a central registry based upon such a plan. They do not do so in the places where it is now operating, indeed they whole-heartedly support this important professional activity. Before accusing anyone of disloyalty, it would be necessary to know whether this disloyalty is to the letter or to the spirit of a law.

If the Central Registry is organized, as it should be, to give good service to patients and opportunity to nurses, it is difficult to believe that worthy superintendents of nurses would in any way oppose its rulings.

Should registered nurses sign their names to "testimonials" of (a) drugs (b) sanitary commodities (c) clothing?

Answer.—(a) There are two points to be considered here: 1. A nurse's recommendation of a drug is worthless because she has not the medical knowledge of a diagnostician and, therefore, has not the scientific knowledge to judge of the therapeutic value of a drug or other therapeutic agent. It is definitely unethical for her to permit her name to be used. 2. So-called "patent" medicines, remedies based on secret formulae, are in themselves unethical according to the standards of medical ethics. The American Medical Association, through its Council on Pharmacy, works ceaselessly in analyzing and evaluating new remedies. Despite their efforts, new preparations of doubtful value are constantly appearing on the market. (b) and (c) Many people believe that it is a violation of good taste to allow one's name to be used in connection with sanitary commodities, clothing and the like, though social judgment on this is tending to change. It is significant that no one has ever seen the name of a registered nurse who has won professional distinction used in such a fashion.

THE first fly should be every bit as interesting as the first robin—and be enormously more important. Now is the accepted time to swat.—*Ohio Health News.*

To Blow Up a Kelly Pad

ONE day, having occasion to blow up a Kelly pad, I sought to improvise something to avoid doing it with my mouth. I borrowed the bulb off the throat and nasal atomizer, found a hard rubber tip such as fits in the bottom of an enema bag, and a piece of rubber tubing about three inches long. I connected the three and slipped the rubber tube over the valve of the Kelly Pad, then pumped the air in. It worked very nicely. I am planning to make one for each ward, using discarded articles for the sake of economy.—Elizabeth Cross, R.N., Letchworth Village Hospital.

Abstracts

H. E. Irish, M.D.: Cod-liver Oil as a Substitute for Cream in Feeding Mixtures for Infants. (*Journal of the American Medical Association*, December 15, 1928.)

ABUNDANT evidence now exists showing that assayed cod-liver oil has definite potency in preventing rickets and xerophthalmia, and in promoting growth through its vitamins A and D. It will probably remain the cheapest and most convenient agent for this purpose. Its food value in presenting digestible fat has been demonstrated in animals.

Certain disadvantages in its use prevent optimum results. Its odor causes antipathy among adult attendants which breeds excuses for not giving it. Its viscidity when given cold causes gagging, choking and vomiting, part of which is due to clumsiness in giving fluids with a spoon to an infant. Together with these factors, too small doses are usually ordered, so that it is rare to find a bottle-fed infant at one year without a rachitic rosary and broadened epiphyses. Adequacy of dosage varies with the potency of the oil, size of the child, season of the year, amount of sunshine and skyshine received, altitude, and proximity to the patient of irradiated human bodies. From 15 drops to several teaspoons daily are recommended as adequate dosage.

A pint of 3 per cent milk contains one tablespoonful of fat, so that if that quantity of cod-liver oil is given, the fat intake is doubled. Fat is the food element most often difficult for infants to digest, protein being the least difficult, with sugar standing midway. Evidences of fat overfeeding are vomiting, constipation with soap stools, and arrested gain in weight.

Disregarding minimum efficient doses, I fed the entire fat requirement in assayed cod-liver oil, after removing the cream from the milk with a self-starting, sterilizable siphon. I wrote a 24-hour formula, following Budin's approximate method and using skimmed milk, 1½ ounces, to the pound of body weight, $^1/_{10}$ ounce of sugar to the pound of body weight, cod-liver oil 3 per cent of the total quantity of skimmed milk, with enough oatmeal water to make up the total 24-hour quantity found by multiplying the amount of each feeding (two ounces more than the month age, up to six months) by the number of feedings in 24 hours. All final fractions were advanced to the next highest whole number. This formula is fed in 5-ounce quantities (two ounces more than the age in months up to six months) five times in 24 hours. It should be mixed while cool, shaken thoroughly and divided in feeding bottles. It is kept cool until feeding time, shaken well and warmed to the body temperature. The oil tends to separate, but remains sufficiently well mixed so that all is taken.

After six months the usual vegetable and cereal feeding was given, and orange juice was fed daily.

The cod-liver oil formula was well taken by all children under ten months. Thereafter, some showed initial aversion, so that smaller doses, increased as tolerated, were used. Clinically the results were good; the pink skin, the rapid gain in weight without increase of the sugar fraction, and the absence of vomiting denoted successful feeding. Constipation tended to occur when the fat content was raised to 5 per cent, but was overcome by adding one tablespoon of extract of malt, U. S. P., to the mixture.

No advance in the signs of osseous rickets was noted, children previously unaffected remaining so. The nervous symptoms, when present, disappeared. The feeding was done in the dark months of January, February and March, in the presence of an epidemic of upper respiratory infection. The mixture was well tolerated during febrile attacks, and gains were constantly noted. The infections that occurred were relatively mild.

May R. Mayers, M.D.: The Prevention of Lead Poisoning. (*Industrial Hygiene Bulletin of New York Department of Labor*, November, 1928.)

IT is to the recent efforts of the Department of Public Health at Harvard University that we owe our present knowledge of a rational treatment for lead poisoning. The treatment has been employed by them in a number of cases of lead poisoning which have come into the Massachusetts General Hospital

and has been found to be very effective indeed. It will be briefly summarized here:

Treatment during the acute attack: The onset of acute symptoms evidences the presence of lead in the circulation in toxic amounts. All efforts at treatment, therefore, should be in the direction of promoting rapid storage of this lead and of reducing any tendency to a further liberation of lead at that particular time from the bones or other points in the body where it had previously been deposited. By this procedure, the amount of lead in the blood may be rapidly reduced in amount. The treatment, therefore, consists in:

1. Increasing the calcium balance in the body, since a positive calcium favors the storage of lead. This can be accomplished by giving the patient a quart of milk plus two grams of calcium lactate per day. In very severe cases, calcium chloride may be given intravenously in doses of 15 c.c. of 5 per cent solution.

2. The use of cathartics, preferably magnesium sulphate, in one-ounce doses.

3. The use of such substances as atropin, nitroglycerin, amyl nitrite, or benzyl benzoate, to relieve muscle spasm in the intestines.

The use of potassium iodide is undesirable during an acute attack, since it increases the elimination of lead from the body by mobilizing the lead which is stored either in the bones or elsewhere. It is distinctly unwise to throw additional quantities of lead into the circulation at a time when toxic doses are already present. Such a procedure may in certain cases precipitate a fatal attack. . .

Treatment after the acute attack has subsided: This should be in the direction of increasing the lead elimination from the body. It should be very cautiously and slowly removed, in so far as possible, from the various places where it had been previously stored, especially from the bones, all of the time taking care that too much is not thrown into the circulation at a given time. This can be accomplished as follows:

1. *Diet.*—The diet should be low in calcium in order that a negative calcium balance be established. This is accomplished by a diet "poor in milk, eggs, green vegetables and certain fruits." The diet suggested by the investigators mentioned is the following:

Meat	Rice
Liver	Tomatoes
Potatoes	Canned corn (cooked without milk)
Tea and coffee without milk	Bananas
Sugar, salt, pepper	Apples (peeled)

Butter fat (prepared by melting the butter in hot water and skimming off the butter fat).

Bread prepared without milk, such as salt-free nephritic bread or soda bicarbonate biscuits or crackers.

2. *Drugs.*—The acid-base balance of the body should be altered by increasing either the acid or alkali reserve, since this favors the mobilization of lead from the places in which it has been stored and helps throw it into the circulation in soluble form for purposes of ultimate elimination. Care must, of course, be taken that toxic amounts of soluble lead are not thrown into the circulation at any given time, for then an acute attack of lead poisoning may be precipitated. The production of an acidosis has been found to be the more desirable therapeutic procedure, and this should be accompanied by a low calcium diet as indicated above. The drugs used to produce the acidosis are: Phosphoric acid, ammonium chloride, potassium iodide.

In cases of nephritis, the administration either of acids or potassium iodide is contraindicated. In these cases, it is desirable to alter the acid-base relations within the body by increasing the alkali reserve. Bicarbonate of soda can be effectively used in these cases in doses of from 20 to 40 grams daily. Evidence of an alkalosis must be carefully watched for.

These therapeutic measures may be continued for a considerable period of time. It has been found, however, that after a certain amount of lead has been removed from the body, it becomes increasingly difficult to remove any more. It is suggested, therefore, that when this point is reached, eliminative treatments cease and that efforts be turned to establishing a positive calcium balance again and returning the remainder of the lead to the bones. This, of course, must be left to the judgment of the physician in charge.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

Nurses' Relief Fund

REPORT FOR DECEMBER, 1929

Receipts

Interest on investments	$900.24
Interest on bank balances	94.63
Income from Jane A. Delano Fund	188.61
Refund of protest fees	3.25
Benefit checks returned and cancelled	135.00

Contributions

Alabama: District 1, 10 cents per capita, $22.70; Thanksgiving offering, $80.10; District 2, $44	146.80
Arkansas: District 6A, $20; District 6B, $20; State Assn., $75	115.00
California: From a former beneficiary	1.00
District of Columbia: Garfield Memorial Hospital Alumnae Assn., $53; Columbia and Children's Alumnae Assn., $28	81.00
Florida: District 6, $12; District 7, $8; District 8, $71	91.00
Georgia: District 1, Grady Hospital Alumnae Assn	25.00
Hawaii: Nurses' Assn. of Hawaii	48.00
Kansas: Lyon County Graduate Nurses' Club	6.00
Maine: Central District—individual members, $9, Central Maine Genl. Hospital Alumnae Assn., $35; St. Mary's Alumnae Assn., $25; Western District—individual members, $4; Maine Eye and Ear Infirmary Alumnae Assn., $52; Children's Hospital Alumnae Assn., $16; Members of Maine Genl. Hospital Alumnae Assn., $10	151.00
Maryland: University of Maryland	100.00
Massachusetts: McLean Hospital Alumnae Assn., $10; Jordan Hospital Alumnae Assn., Plymouth, $15; Massachusetts Genl. Hospital Alumnae Assn., $50	75.00
Mississippi: State Assn.	285.00
Missouri: District 1 (St. Joseph)—Missouri Methodist Hospital, $33; District 2, (Kansas City)—Research Hospital, $50; District 3 (St. Louis)—St. Luke's Alumnae Assn., $78; Jewish Hospital Alumnae Assn., $10; Missouri Baptist San. Alumnae Assn., $11; Lutheran Hospital Alumnae Assn., $160; District 7, $25	$367.00
Nebraska: District 3	125.50
New Hampshire: Sacred Heart Hospital Alumnae Assn., Manchester, $25; Littleton Hospital Alumnae Assn., $2	27.00
New York: District 1—Lady of Victory Hospital, student Nurses, $25; Lady of Victory Hospital Alumnae Assn., $37.50; Buffalo Woman's Hospital Alumnae Assn., $25; individual contribution, $1; District 3—Arnot Ogden Memorial Hospital Alumnae Assn., $50; District 13—St. Vincent's Hospital Alumnae Assn., $50; Manhattan and Bronx card party and individual contribution, $115; New York Hospital Alumnae Assn., 1 member, $5; Port Chester Hospital student nurses, $5; Port Chester Hospital Alumnae Assn., 15 members, $15; Post-Graduate Hospital Alumnae Assn., one member $5; Cochrane Training School Alumnae Assn. of St. John's, Riverside, $25; District 14, Brooklyn, Jewish Hospital Alumnae Assn., $134; St. John's Hospital Alumnae Assn., $25; Williamsburg Hospital Alumnae Assn., $5; Methodist Episcopal Alumnae Assn., $100; Brooklyn Hospital Alumnae Assn., $100	723.00
Oklahoma: District 1, $59; District 3, $5; District 4, $63; District 5, $13	140.00
Texas: District 1, $30; District 2, $61; District 3, $150; District 6, $74; District 7, $42; District 8, $255; District 10, $41; District 11, $53; District 12, $114; District 13, $17; District 15, $10; State Assn., $100;	947.00
Virginia: Individual contributions	2.44
Total Receipts	$4,778.47

Disbursements

Paid to 188 applicants	$2,672.00
Salaries	227.53
Printing	5.58
Stationery	7.00
Protest fees	3.25
	$2,915.36
Excess of income over expenditures for month of December, 1928	$1,863.11

All contributions to the Nurses' Relief Fund should be made payable to the Nurses' Relief Fund and sent to the state chairman. She, in turn, will mail the checks to the American Nurses' Association, 370 Seventh Avenue, New York, N. Y. If the address of the state

chairman is not known, then mail the checks direct to the Headquarters Office of the American Nurses' Association at the address given above. For application blanks for beneficiaries apply to your own alumnae or district association, or to your state chairman. For leaflets and other information address the state chairman or the Director of the American Nurses' Association Headquarters.

The Isabel Hampton Robb Memorial Fund

REPORT TO JANUARY 9, 1929

Previously acknowledged	$33,808.62
Contributions	
Kansas: State Nurses' Assn.	25.00
New York: Brooklyn Hospital Alumnae	10.00
Pennsylvania: District 3	10.00
Total	$33,853.62

MARY M. RIDDLE, *Treasurer.*

The McIsaac Loan Fund

REPORT TO JANUARY 9, 1929

Balance, January 1, 1929	$776.21
Contributions	
Kansas: State Nurses' Assn.	50.00
New York: Brooklyn Hospital Alumnae	10.00
Pennsylvania: District 3	10.00
Interest for one year on loan of $100	2.00
Interest to close loan of $200	15.70
Total	$863.91
Disbursements	
None.	
Balance, January 9, 1929	$863.91

MARY M. RIDDLE, *Treasurer.*

Contributions to these funds are welcomed from associations or individuals. Checks should be made out separately and sent to the Treasurer, care *American Journal of Nursing*, 370 Seventh Avenue, New York. Application blanks for scholarships or loans may be obtained from the Secretary, Katharine DeWitt, at the same address.

International Council of Nurses

The quadrennial meeting of the International Council of Nurses will be held in Montreal, Canada, July 8–13, next.

Nurses are advised that no further reservations for single rooms can be considered by the Committee on Arrangements for the Montreal meeting. This Committee has its office at the Royal Victoria Hospital, Montreal. It is obviously the part of wisdom to make early reservations.

TRANSPORTATION.—Convention rates at fare and one-half will be authorized on the *Identification* Certificate Plan, tickets to be on sale July 4–10, and bearing final return limit July 20, provisions being made for validation on any day to and including final return limit. Tickets may also be sold for this convention on the basis of fare and three-fifths with final return limit of thirty days, in addition to date of sale, on Identification Certificate plan. Consult local ticket agents.

All nurses should reach Montreal by evening of July 7.

Caroline Garnsey, Executive Secretary of the New York State Nurses' Association, 370 Seventh Avenue, New York, has been appointed National Chairman. The following regional representatives have been appointed and all local transportation arrangements will be made through them:

North Eastern (New Jersey, Maryland, Delaware, Pennsylvania, New York, District of Columbia—Marietta B. Squire, 105 South Grove Street, East Orange, N. J.

South Atlantic (Florida, Georgia, North Carolina, South Carolina, Virginia, West Virginia)—Martha V. Baylor, Roanoke Hospital, Roanoke, Va.

West Coast (Washington, Oregon, Idaho, Nevada, California)—Anna C. Jammé, 609 Sutter Street, San Francisco, Calif.

Mountain States (Montana, Wyoming, Utah, Arizona, Colorado, New Mexico)—May Kennedy, 6400 Irving Park Blvd., Chicago, Ill.

South Central (Missouri, Kansas, Oklahoma, Texas)—A. Louise Dietrich, 1001 E. Nevada St., El Paso, Texas.

North Central (Minnesota, Ohio, Iowa, Nebraska, Illinois, Wisconsin, North Dakota, South Dakota, Indiana, Michigan)—Loretta Mulherin, St. Joseph's Hospital, Denver, Colo.

Gulf (Tennessee, Arkansas, Louisiana, Mississippi, Alabama, Kentucky)—Mrs. B. S. Cawthone, Bureau of Public Health Nursing, Memphis, Tenn.

Army Nurse Corps

During the month of December, 1928, orders were requested directing transfer of members of the Army Nurse Corps to stations indicated: To Letterman General Hospital,

San Francisco, Calif., 2nd Lieut. Sara Connerth; to Station Hospital, Fort Sam Houston, Texas, 2nd Lieut. Margaret R. Hall; to Station Hospital, Fort Sheridan, Ill., 2nd Lieuts. Mary A. Kalouner, Mary E. Ray; to Station Hospital, Fort Sill, Okla., 2nd Lieuts. Josephine H. Balestra, Leo Elizabeth Williams; to Walter Reed General Hospital, Washington, D. C., 2nd Lieuts. Teresa Fitzgerald, Annie G. Fox; to the Hawaiian Department, 2nd Lieut. Anna K. Reidelbach.

Ten have been admitted to the Corps as 2nd Lieuts.

The following named, previously reported separated from the Corps, have been reassigned: Maude Spinner Gurney, Fort Lewis, Wash.; Annamarie Koch, Walter Reed General Hospital, Washington, D. C.

The following named are under orders for separation from the Corps: Ivy May McAchren, Irene Bell, Mary G. Satterfield, Margaret Sindorf, Marjorie Benjamin, Mabel M. Lesley, Miriam M. Luca, Florence Uhlhorn, Katye E. McKay.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

During the month of December, eight nurses have been appointed and assigned to duty.

The following transfers were made: To Canacao, P. I., Mabel L. Powell, Chief Nurse; to Chelsea, Mass., Marjorie E. Wheeler; to Great Lakes, Ill., Frances L. Winkler, Chief Nurse; to Mare Island, Calif., Mary H. King; to Newport, R. I., Blanche Kennedy; to New York, N. Y., Catherine A. McNelis; to Norfolk, Va., Flora A. Murphy; to Parris Island, S. C., C. Virginia Besson; to Pearl Harbor, T. H., Carrie H. Lappin, Chief Nurse; to Puget Sound, Wash., Anna Lee Merritt; to San Diego, Calif., Alice B. Cameron, Kathleen O'Brien, Chief Nurse; to St. Thomas, V. I., Anna I. Cole, Chief Nurse, Laura A. Roburds, Ivy H. Keene; to Washington, D. C., Naval Medical School, Minnie D. Stith, Chief Nurse.

The following nurses were separated from the Service: Gaylena Millwee, Maude Bush, Ada E. Welty, Mary E. Panak.

Elisabeth Leonhardt, Chief Nurse, and Margaret Pierce, have been transferred to the Retired List.

J. BEATRICE BOWMAN,
Supt., Navy Nurse Corps.

KATHERINE TUCKER, R.N.

Recently appointed Director of the National Organization for Public Health Nursing. Miss Tucker will take office March first.

U. S. Public Health Service

The following transfers, reinstatements, and new assignments have been made in the U. S. Public Health Nursing Service during the month of December, 1928:

Transfers: Elizabeth King to Baltimore, Md.; Margaret Boyer to Chicago, Ill.; Rosalie Manwiller to Memphis, Tenn.; Mary Nichol to Buffalo, N. Y.; Clara Brown to San Francisco, Calif; Monelta Berlis to Norfolk, Va.; Gertrude Turner to Key West, Fla.; Lenna Davis to Pittsburgh, Pa.; Ethel Maynor and Willie York to Ellis Island, N. Y.

Reinstatements: Mary Fitzpatrick, Sheila Fleming, Lela Williamson, Mary Andrews, Lula Amrock, Elsie Fields, Erma G. Morrison, Daisy Hesse.

New Assignments: Twenty-two.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

U. S. Veterans' Bureau

REPORT OF NURSING SERVICE FOR DECEMBER, 1928

New Assignments: thirty-eight.
Reinstatements: May Jones, Mary I. Wright.

Viola Brown, Lois Garraway, Hannah Flahive, Clara M. Lawson, Fay Samms, Anita L. Kelly, Alona G. Trussell, Mattie Fulmer, Florence Jennings, Clara Schuenke.

Transfers: Kathleen Dorsey, Chief Nurse, to North Chicago, Ill.; Sara A. Lee, Chief Nurse, to St. Cloud, Minn.; Julia Lyons, Assistant Chief Nurse, to Bronx, N. Y.; Gracia Brann, Chief Nurse, to Gulfport, La; Hannah Brandt, Chief Nurse, to Sheridan, Wyo.; Mary Culbertson, Chief Nurse, to Tacoma, Wash.; Flora Schumacher, Chief Nurse, to Ft. Bayard, N. M.; Alice Blake, Chief Nurse, Grace Stuhr, Gladys Bock, Nellie Coad, Emma Herbert, Edna C. Johnson, Mary Ferrand, Lydia Richter, Mary A. Prince, Vera Dumas, Eva I. Hermes, to Portland, Ore.; Aleda C. Johnson, Rose Schwartz, to Ft. Snelling, Minn.; Rose Behan, Hannah Atkinson, to Maywood, Ill.; Mary Brady, to Muskogee, Okla.; Mary Bartsch, to Ft. Lyon, Colo.; Mary Reddig, to Philadelphia, Pa.; Florence Jeffers, to Bronx, N. Y.; Mary Woods, to Perry Point, Md.; Katherine Collins, to Oteen, N. C.; Martha J. Lacy, to Palo Alto, Calif.; Eileen C. Dyckman, to San Fernando, Calif.; Rose Mary McClain, to Regional Office, Pittsburgh, Pa.

MARY A. HICKEY,
Supt. of Nurses U. S. V. B.

Indian Service

The following changes have taken place since December 8:

Transfer: Esther Sandstrom to Hopi Agency, Toreva, Arizona.

Appointment: one.

Resignation: one.

ELINOR D. GREGG,
Supervisor of Nurses.

Health Education in the Philippines

Sally Lucas Jean, School Consultant of Cleanliness Institute, and school health adviser to the Metropolitan Life Insurance Company, the National Dairy Council and others, former director of the American Child Health Association, is on her way to the Philippine Islands to develop a health education program in the schools there. Her trip is being made at the request of Governor-General Henry L. Stimson, and she is the guest of the government of the Philippines. Miss Jean is to inaugurate the program which will be carried out by Edna Gerken, Supervisor of Health Education in Fall River, Mass., over a two-year period. Miss Gerken sailed with Miss Jean.

National Conference of Social Work

The fifty-sixth meeting of the National Conference of Social Work will take place in San Francisco, Calif., June 26 to July 3, under the leadership of Porter R. Lee, the president, who is director of the New York School of Social Work.

The Conference is open to anyone who wishes to attend. All railroads offer tourist rates, with special arrangements for vacation trips. Adequate hotel space has been assured. Additional information about the Conference can be secured from Howard R. Knight, General Secretary, 277 East Long Street, Columbus, Ohio.

Institutes and Special Courses

California: The NORTHERN CALIFORNIA LEAGUE OF NURSING EDUCATION sponsored an institute for nurses in San Francisco, January 2–4. This is an annual event given between fall and spring semesters. The program was arranged with special reference to the work of directors of schools, instructors and supervisors. The faculty of schools in San Francisco and neighboring cities constituted an attendance of 287. Concentrated attention was given to the following subjects: "Use of Periodicals in the Classroom"; "Faculty Responsibility in Vocational Guidance"; "Teamwork of Ward Supervisors and Nursing School Office"; "Results of Classroom Teaching on Actual Nursing Care." One session was devoted to the teaching of a class in Nursing Procedure. After the dismissal of the class, there was a discussion on methods used with suggestions for improvement. Each afternoon for two hours the institute was under the direction of Edna Bailey, Ph.D., Professor of Education in the University of California. Her topics were: "Organization of Teaching Units in the Basic Subjects"; "Technics of Teaching Nursing Procedures"; "Adaptation of Subject Matter and Methods to Varying Levels of Ability; Ways of Measuring Achievement." Dr. Bailey also led the discussion of the teaching methods used in the demonstration. This was Dr. Bailey's second year of work with the institute and she was able to give a comprehensive and exceedingly useful

contribution to directors and teachers even within the limitations of three afternoon sessions. The California League feels that an institute at this time of the year serves as an inspiration to the faculty for the work of the spring semester. It also encourages summer-session work at the University.

State Boards of Examiners

Colorado: The STATE BOARD OF EXAMINERS has the following officers: President, Loretto Mulherin, St. Joseph's Hospital, Denver; secretary, Irene Murchison, State House, Denver.

Michigan: The MICHIGAN BOARD OF REGISTRATION OF NURSES AND TRAINED ATTENDANTS will hold an examination for graduate nurses and trained attendants in Lansing, March 7 and 8, 1929. An examination for graduate nurses will also be held in Detroit, April 17 and 18, 1929. Mrs. Ellen L. Stahlnecker, Secretary, 622 State Office Building, Lansing.

State Associations

California: The PRIVATE DUTY SECTION of the State Association held mid-year meetings simultaneously in San Francisco and Los Angeles on January 10. The San Francisco meeting was conducted by Marie Kelly Wulf, President of the Section; the Los Angeles meeting by S. Gotea Dozier, Vice President of the Section. The same topics were discussed at both meetings: "Organization"; "Bureaus of Nursing Service"; "Methods of Keeping Up with Newer Phases of Nursing." Both were large and enthusiastic gatherings of private duty nurses who gave full rein to discussion on the problems before them. The joint boards of directors of the California nursing organizations held their regular meetings in Los Angeles on January 12. Changes in the Nurse Registration Act which was introduced in the Legislature early in January were discussed with the Committee on Legislation as the main order of business. California nurses are hard at work on raising the quota for the American Nurses' War Memorial at Bordeaux. Returns are coming in from the districts. California hopes to be early in reporting its quota raised.

Colorado: The COLORADO STATE GRADUATE NURSES' ASSOCIATION will hold its annual meeting in Denver, February 5–7, at the Brown Palace Hotel. There will be a councillors' meeting on Monday, February 4, at 7 p. m., followed by a Board of Directors' meeting.

Connecticut: The state organizations of nurses will hold their annual meetings at the Bond Hotel, Hartford, February 6–8.

Maine: The sixteenth annual meeting of the MAINE STATE NURSES' ASSOCIATION was held in the Sunrise room, Eastland Hotel, Portland, January 4 and 5. Friday morning was given over to the registration of the two hundred and twenty-two delegates and members, Executive Committee meeting and the business meetings of the sections. At the general session, Friday afternoon, the invocation was given by the Rev. Daniel I. Gross, D.D. The address of welcome was extended by the Honorable William H. Barlow, City Manager, and the response by Elizabeth Selden. The reports of the District presidents and the standing committees were given followed by the President's address by Rachel A. Metcalfe after which the meeting adjourned for tea, given by the Alumnae of the Maine Eye and Ear Infirmary in the library of the hospital. In the evening a banquet at the Eastland was enjoyed. Edith L. Soule, Chairman of the Public Health Section, presided at the post-prandial exercises. Reports of the various divisions of the Public Health Nursing Service were given. The principal speaker was Sophie Nelson of Boston, Chief Nurse of the John Hancock Insurance Company, who gave a most interesting talk on the "Relation of the Public Health Nursing Service to the Public."

Saturday morning, after the opening exercises, Margaret Pearson, Chairman of the Private Duty Section, introduced Emma J. Collins, Director of the Brooklyn, N. Y., Official Registry, who took as her subject, "The Coöperative Movement Among Nurses Which Is Called the Official Registry," and gave a most interesting address. This was followed by the League of Nursing Education, Mary Osborn, Chairman, presiding. After the reports of the Section, Elizabeth C. Burgess of Teachers College, President of the National League of Nursing Education, gave a most instructive talk on the purposes and organization of the League. After this came the meeting of the State Committee of the American Red Cross, C. Maude Culton, Chairman, presiding. She introduced Ida F. Buklin, Assistant Director of the National Red Cross Nursing Service, Washington, D. C., who gave a very able talk on "The American Red Cross and the Nurse." The afternoon session was

devoted to unfinished business, reports of the Legislative and Resolutions committees and the report of the tellers. The following officers were elected: President, Louise P. Hopkins; vice presidents, Mrs. Theresa R. Anderson, Eleanor Campbell; secretary, I. C. Johansen; treasurer, Mrs. Lou S. Horne; director, Rachel A. Metcalfe.

District and Alumnae News

Alabama: Birmingham.—DISTRICT 1 held its regular meeting at the clubhouse, Annice Jackson presiding. After the regular business proceedings Miss Denny presented a suitable program for Alabama Day. Miss Petersen read a Christmas greeting to the Alabama Red Cross nurses from Clara D. Noyes, chief of the Red Cross Nursing Service. The district nurses act as big sisters to the Sayreton School children, and Miss Jackson reminded the members that the Christmas entertainment for the nurses would take place December 21, and all members were urged to attend. **Selma.**—The following officers were elected by DISTRICT 5 for 1929: President, Mrs. Henry Garner; vice presidents, Marie Dunden, Martha Mayton; secretary, Jennie Mae Bennett; treasurer, Mrs. Annie McKee. The past year was a very successful one for this district. It had a delegate at the Biennial and five at the State convention.

Colorado: Longmont.—The Christmas cantata, "On to Bethlehem," was given by the LONGMONT HOSPITAL NURSES' CHORUS in December at the Methodist Church, and proved a musical treat.

Connecticut: Bridgeport.—The BRIDGEPORT HOSPITAL TRAINING SCHOOL ALUMNAE MEMBERS are asked to get in touch with Mrs. George E. Hall, 78 Hough Avenue, if they have not received the 1928 Bulletin. Bulletins have been mailed to every one whose address was available, but there are still some waiting for the want of an address. Please pass the word along.

Georgia: Columbus.—On December 7, the FIFTH DISTRICT held its regular meeting in the Parish House of Trinity Episcopal Church. A very instructive and enthusiastic program was arranged. Miss Ruby Jenkins, a recent graduate, gave a talk on "Ethics of the Private Duty Nurse." Eva Chalkley presented a paper on "The Private Duty Nurse as an Educator in the Home." **Macon.**—OGLETHORPE ALUMNAE ASSOCIATION. The 1928–29 officers are: Emily Bancroft, president; Tillie Shuman, vice president; Emma Wickliffe, secretary, and Elizabeth Miscally, treasurer. The Association has annually provided at Christmas time for a deserving family. A sick committee looks after Alumnae members who are ill. Another poor family has been "adopted" by the Alumnae this year. The idea of the Association is to keep each member interested, active and happy by having a real part in the work of the organization. **Savannah.**—FOURTH DISTRICT: A regular monthly meeting of the Association was held December 27, at the Savannah Hospital; fifteen members were present. The Public Health Section made an interesting report of activities, through the chairman, Mrs. Anne Rivers. Hospitality and other committees also made reports. The Park View and St. Joseph's Alumnae Associations reported sale of all League calendars allotted to them. The Directory Committee's report was read. The District organization is making plans for a linen chest as a means of raising funds. SAVANNAH HOSPITAL ALUMNAE ASSOCIATION: Mrs. Dell Coleman, president, M. Ogletree, vice president, E. Griffin, secretary, and E. Bennett, treasurer. Meetings are held the third Wednesday in each month, at the hospital. Active members, 28; associate members, 2; and members in good standing with District State and National organizations, 18. The Alumnae has subscribed $18 to the Nurses' Relief Fund, in addition to contributing to the Charity Hospital Building Fund and to other worth-while movements. The Association has started a relief fund for its own members who are ill. The TELFAIR HOSPITAL ALUMNAE ASSOCIATION was organized in 1921; during 1927–28 it had 26 active members; associate members, 18. Meetings are held the first Wednesday in each month from October to May. The main program for 1927–28 was the furnishing of a classroom in the hospital, for student instruction. This year the Alumnae expects to add to the equipment of the classroom and furnish a room in the new wing of the hospital. Officers for 1928–29 are: Maybelle Jensen, president; Mrs. Bertha Cole Stevens, vice president; Eleanor Medlin, secretary-treasurer. Helen Hatch is chairman of the Educational Committee. The PARK VIEW SANITARIUM closed in December, 1925, but the ALUMNAE is still active, with fifty active and associate members. Monthly meetings are held regularly for nine months out of each year, with a special program. During 1927–28 $15 was contributed to Nurses' Relief; $24 to State Headquarters; $5 to the Tallulah Falls Industrial School in the mountains of north Georgia. Each member

contributes one dollar to a fund for special contributions. This obviates other forms of money-making. The Association suffered the loss of one of its charter members the past year—Ella Symons.

Illinois: Springfield.—The Sisters of St. John's Hospital had a formal opening of the new Nurses' Home, January 13.

Indiana: South Bend.—The SECOND DISTRICT held its annual meeting at the Children's Dispensary, November 10. The following officers were elected for 1929: President, Marion Moore; secretary, Mrs. Mabel Ackley; treasurer, Mrs. Leona Singer. A report was given by Marion Moore of the State meeting at Indianapolis.

Iowa: Des Moines.—An annual event of the IOWA METHODIST HOSPITAL ALUMNAE ASSOCIATION, which is looked forward to from January to January, is the "homecoming." On January 9, seventy-five graduates of the school met at the Nurses' Home to renew acquaintances and meet new graduates. Election of officers resulted as follows: President, Mrs. Ellen Tellier; vice presidents, Mabel Kenyon, Gertrude Frey; treasurer, La Vera Stalker; secretary, Bernice Nelson; historian, Catherine B. Earhart; board members, Isabel McHarg and Mrs. Iva Everett. DISTRICT 7 met for dinner at Younker's Tea Room, January 10. Following dinner the regular business meeting was called. The following officers were elected: President, Molanda Silzer; vice presidents, Blanche Flo, Laura Henderson; secretary, Maude Bowen; treasurer, Aletha Hobbs; directors, Mrs. Vivian Walkup and Maude E. Sutton. DISTRICT 7 regrets exceedingly to lose from its organization Helen Moninger, who leaves Iowa, February 1, to assume her duties as head supervisor of obstetrics at Grant Hospital, Chicago. She has served her alma mater in a like capacity for seven and one-half years. **Dubuque.**—DISTRICT 3 held its regular meeting, with election of officers, January 7. President, Helen M. Hierstein; vice presidents, Eunice Brackett, Ann Keller; secretary, Meryl Norton; treasurer, Hazel Nading. Kathryn Tully has succeeded Ella Rose Holm as instructor at Mercy Hospital. Miss Holm is taking some special work in Milwaukee. **Washington.**—On January 3, dedicatory exercises were held at the new nurses' home of the WASHINGTON COUNTY HOSPITAL. The building is a beautiful structure of colonial type, modern in every particular. The furnishings harmonize throughout. It is located in the northwest corner of the hospital park, a tract of eleven acres, and the outlook on all sides is pleasant. SECOND DISTRICT held its regular meeting in Washington, at the new nurses' home, January 12. A splendid program preceded election of officers. District members had an opportunity to see the new home. All are loud in their praises of the new building.

Journal poster made by Mary Alice Vanarsdall, Student Nurse, St. Vincent's Hospital, Indianapolis, Indiana.

Kansas: Topeka.—The second annual meeting of the KANSAS STATE NURSES' ASSOCIATION will be held, March 12, at the Stormont Nurses' Home. There will be a general business session including an annual report of the Registry Committee.

Michigan.—The annual conference of the MICHIGAN PUBLIC HEALTH ASSOCIATION and the MICHIGAN DEPARTMENT OF HEALTH was held in Lansing, January 9–11. A luncheon meeting for public health nurses was a part of the conference at which Ellen Atchison, District Supervisor of Nursing, Metropolitan Life Insurance, Detroit, led the discussion. **Battle Creek.**—The annual meeting of the BATTLE CREEK DISTRICT was held at West Hall Sanitarium. Mary C. Wheeler, State Secretary, gave an interesting talk on organization. The following officers were elected for the following year: President, Ruth Tappan, Battle Creek; vice president, Josephine Nichols, Battle Creek; corresponding secretary, Helen L.

Juckett, Albion; recording secretary, Clara Gasser, Battle Creek; treasurer, Mrs. Addie Taylor, Battle Creek; directors, Mrs. Elizabeth Nichols, Fantine Pemberton. **Detroit.**—The annual meeting of the DETROIT DISTRICT of the Michigan State Nurses' Association was held on January 11, at the Activities Building of the League of Catholic Women. A dinner preceded the meeting. A silent tribute to three members of the District, who died during the year, was given by the two hundred nurses present before the opening of the meeting. Mrs. Emma Fox, parliamentarian, was the honor guest of the meeting. The following officers were elected to serve during the coming year: Grace Ross, president; Margaret Gordon, Maybelle Johnston, vice presidents; Dora De Long, secretary; Ethel Jardine, treasurer. Mrs. Anne L. Hansen, President of the National Organization for Public Health Nursing, will be the speaker at the February meeting of the Detroit District. The Public Health Section of the Association will have charge of the meeting. Mary M. Roberts, Editor of the *American Journal of Nursing*, was the speaker at the January meeting of the ALUMNAE ASSOCIATION of the FARRAND SCHOOL OF NURSING, Harper Hospital. Miss Roberts discussed current problems in nursing.

Nebraska: Lincoln.—The ORTHOPEDIC HOSPITAL SCHOOL OF NURSING, under the leadership of the Superintendent of Nurses, Mrs. Leroy Penfold, has organized a club for the study and discussion of papers, journals and books relating to the care of the patient, nursing education and social functions. The faculty of the school and the students compose the membership. The occupational therapy teacher is an interested member. It meets every two weeks. The report of the work of the Grading Committee as published in each issue of the *American Journal of Nursing;* "Nurses, Patients and Pocketbooks," with articles on the newer procedures, are the subjects for this year. In November a dinner was given for the State Director of Nursing Education, Phoebe M. Kandel, in appreciation of the help she has given the school in helping it to raise its educational standards. Dr. Matthai, Superintendent of the Hospital, and a Senior student, spoke, and the pin of the Club was presented Miss Kandel. The ORTHOPEDIC HOSPITAL ALUMNAE has been raising money for a scholarship loan fund. This will be the first scholarship to be established in the state. The school is accepting only high school graduates; it has established an affiliation with the Illinois Training School, Chicago.

New Jersey: East Orange.—The annual meeting of the HOMEOPATHIC HOSPITAL OF ESSEX COUNTY was held on January 8, when the following officers were elected: President, Marie C. Leidig; vice president, Anna J. Short; secretary, Edna M. Vanderhoof; corresponding secretary, Mildred H. Farrash; treasurer, Minnie E. Nagle.

New York: Binghamton.—The annual meeting of the NURSES' ALUMNAE ASSOCIATION OF BINGHAMTON CITY HOSPITAL TRAINING SCHOOL FOR NURSES was held January 3. The following officers were elected: President, Iva Robinson; vice president, Etta B. Scott; recording secretary, Ruth C. Teal; corresponding secretary, Gladys Westbrooke; treasurer, Ethel Thornburn; directors, Ruby Maxon, Rita Ford Hiener, Anna Sabol and Ethel Moulton Hill. **New York.**—The annual meeting of the NEW YORK POST-GRADUATE HOSPITAL NURSES' ALUMNAE was held at the Nurses' Home on January 8. Jean Strathie was reëlected president; Margaret Tucker, first vice president; Agnes Williams, treasurer; Sarah Mandigo, secretary. A letter of congratulation on her reëlection with an appropriate gift was sent from the open meeting to Miss Strathie, who was absent for the first time in seven years, owing to illness.

Ohio: Alliance.—DISTRICT 1 held its annual meeting, January 22, in Alliance at the Alliance Woman's Club. Program—Election of officers, amendment of constitution and by-laws, special music and a surprise. The "mite boxes" were turned in at this time. **Cincinnati.**—The regular monthly meeting of DISTRICT 8 was held January 28 at the Bethesda Hospital. The program was given by the Private Duty Section. The Public Health Section will hold its regular monthly meeting, February 7, at the Emmanuel Community House. George Seyler, Works Manager of the Lunkenheimer Company, will talk on industrial problems. The Emergency Relief Committee will have a sale on the afternoon and evening of February 8 at the American Legion Headquarters. All District members are urged to attend. **Cleveland.**—The December meeting of DISTRICT 4 was in the form of a Christmas party, held at the Cleveland Nursing Center. The annual meeting was held on January 15. **Columbus.**—DISTRICT 12 held its annual meeting on the evening of January 10, in the Central Presbyterian Church, preceded by a dinner. Annual reports were given, and officers elected.

Pennsylvania: Ashland.—The ALUMNAE ASSOCIATION OF THE ASHLAND STATE HOSPITAL

TRAINING SCHOOL held its annual meeting and banquet, December 12, at the Ferguson Hotel, Shenandoah. Esther J. Tinsley, State President, was the speaker. The following officers were elected for the ensuing year: President, Mary M. Kurchinsky; vice presidents, Ida J. Lockett, Anna T. Jenkins; secretary, Nellie M. Weaver; treasurer, Martha Nochton; associate secretary, Kathryn McAndrew. **Philadelphia.**—Members of the PRESBYTERIAN HOSPITAL ALUMNAE feel that a friend of nurses has been lost in the death of Dr. Joseph Sailer. He had been connected with several of the Philadelphia hospitals and also worked overseas during the war. Elizabeth Ross has been appointed Superintendent of Nurses of the Schools of the Hospital of the Graduate School of Medicine, University of Pennsylvania, succeeding Miss Goodnow, who has held the position for some years. **Pittsburgh.**—The annual meeting of the MONTEFIORE HOSPITAL NURSES' ALUMNAE ASSOCIATION was held December 3. Officers for the ensuing year were elected: President, Mary C. Pitler; vice president, Mary Bechtel; secretary, Sadye N. Flom; treasurer, Beatrice G. Williams.

Rhode Island: Woonsocket.—The monthly meetings of the WOONSOCKET HOSPITAL NURSES' ALUMNAE ASSOCIATION are held each month on the third Tuesday of the month.

Wisconsin: Milwaukee.—DISTRICTS 4 AND 5. The annual Children's Christmas party was held Friday, December 21, at Nursing Headquarters. Ethel J. Odegard, President of the Fourth and Fifth Districts, acted as hostess.

Deaths

Alice Aherne (class of 1902, Germantown Hospital, Philadelphia, Pa.), on December 27, after a short illness.

Ruth Hermina Bridge (class of 1916, Johns Hopkins Hospital, Baltimore, Md.), on December 24, in St. Luke's Hospital, Cleveland, Ohio, after an illness of less than two days, of influenza, contracted while caring for patients with that disease, as a member of the Visiting Nurse Association. Miss Bridge was born in Ohio and had done her work there, with the exception of a year spent in St. Louis, two years overseas during the war, and three years in Constantinople. She had taught in the Youngstown Hospital, Youngstown, the Miami Valley Hospital, Dayton, and the General Hospital, Cincinnati. Miss Bridge went abroad with the Johns Hopkins Unit, and served in France for nearly two years. Her return, in March, 1919, to her home in Franklin, was celebrated by an ovation in which the whole town participated. Miss Bridge had recently taken a year's course at Teachers College, New York, where she obtained her Master's degree. When her body was brought home for burial, with military honors, the town again showed its appreciation of her worth, for business was suspended for the hour during which the services were held. None knew Miss Bridge but to respect her unusual ability as a teacher and an executive. She was extremely interested in all phases of nursing—no problem was too difficult for her to attack. She had a wide acquaintance. She had answered the call of the sick poor in the District just as she responded to every other demand upon her resources during her nursing career. Her friends will always remember her willingness, resourcefulness, untiring interest and faithfulness to the task.

L. Agnes Daspit (class of 1904, Touro Infirmary, New Orleans, La.), on January 4, in New Orleans, of influenza, having given up her Christmas holidays to minister to those suffering from the epidemic. Ever since her graduation, Miss Daspit has been one of the outstanding figures in the nursing work of her state. During the period of the war she was director of the American Red Cross Nursing Service of the Gulf Division, and was active in Red Cross work until the time of her death. She was president of the Touro Alumnae Association for many years, and was at one time president of the Louisiana State Nurses' Association. It was during her term as state president that the Central Directory for Nurses was established in New Orleans. For twelve years she was chairman of the Central Directory Committee, and her resignation from this body, tendered a few years ago on account of ill health, was accepted by the District Association with great regret. At the time of her death she was vice president of the New Orleans District. She has a host of friends who mourn her passing, for she gave her best to all with whom she came in contact. She will live in the memory of those who knew her best, and her example and what she stood for will never die.

Annice Harriet Davis (class of 1926, Wilmington General Hospital, Wilmington, Delaware), on December 5, in the Salem, N. J., Memorial Hospital, of pneumonia, after an illness of two weeks. After her graduation, Miss Davis nursed private cases for some time, and then went to Salem. She had many friends.

Our Contributors

Julia Irene Kemp, R.N., is working for a degree from the University of Chicago, and is a staff nurse in the University of Chicago Clinics where she "has done a very splendid piece of nursing in the Men's Surgical Division." She writes: "Acknowledgment is due Dr. Chester M. Van Allen, Assistant Professor of Surgery, for constructive criticism. Most of the illustrations were taken from Sauerbruch, F., 'Die Chirurgie der Brustorgane,' Springer, Berlin, volume I."

Many nurses will agree with **Carrie M. Hall, R.N.,** that true social change is a slow process. As chairman of the Nurses' Committee on Financing Grading, Miss Hall has inspired thousands of nurses with her own belief in the importance of the work, as the gratifying reports of her committee show.

Jean Wilson, Reg.N., efficient Executive Secretary of the Canadian Nurses' Association, prepared for the Association's Committee on Publicity the article on that organization.

A qualified observer says of **Mary R. Morrissey,** who is librarian at the Sheppard-Enoch Pratt Hospital, Towson, Md., "She is a modest person who has not let herself go as far as she should in her paper."

We are indebted to the faculty of the Illinois Training School for this second "Study of Nursing Care." It is timely when there is everywhere so much discussion of the growing importance of psychiatric training.

Now that **Marie E. Miller, R.N.,** graduate of the Pasadena Hospital School of Nursing, has broken the ice for the office nurses, the editors hope for a flood of correspondence and suggestions from others in that highly specialized branch of nursing.

Phoebe M. Kandel, M.A., R.N., is Director of Nursing Education, serving under the Bureau of Examining Boards of Nebraska.

Journal readers will remember "The Romance of Medical Research," which appeared last year, in which **Konrad Birkhaug, M.Sc., M.D.,** told of his own discovery of the cause of erysipelas. Dr. Birkhaug is Associate Professor of Bacteriology, University of Rochester School of Medicine and Dentistry, Rochester, N. Y.

Grace Watson, M.A., R.N., speaks with glowing enthusiasm of the coöperation of doctors with nurses in teaching nurses. Out of the study described in this issue, in which nurses watched the actual filling of the colon, has come a suggestion that X-ray demonstrations be used in teaching the physiology of the heart and respiratory system.

Reprints of **Virginia McCormick's** article on the Alumnae Association, which was prepared at A. N. A. Headquarters, are available. It is expected that they will be widely used by the officers of alumnae, district and state associations.

The hospital administration at the Hartford Hospital is quite as enthusiastic as the Nursing Department about the good influence exerted by the system of Honors and Credits of **Rachel McConnell, R.N.**

Although the article of **Mary E. Stebbins, R.N.,** is concluded in this number, we hope that *thinking* on rural nursing will continue actively.

Marguerite Breen works with the Minnesota Public Health Association, and has been a contributor to *Hygeia* and other publications.

Bertha H. Lehmkuhl, R.N., Director of the School of Nursing, Fifth Avenue Hospital, New York City, knows well the ever-widening circle of influence of Lydia Anderson, a guide, philosopher and friend to so many thousands of nurses.

The whole nursing world will rejoice over the endowment of the Yale School of Nursing and not alone because of the splendid contribution it enables the school to make to nursing education. It is a well-merited recognition of **Dean Annie W. Goodrich's** marvellous vision, her inspirational leadership, her courageous idealism.

Andrew H. MacPhail is Assistant Professor of Educational Psychology and Director of Psychological Testing at Brown University, Providence, R. I.

The paper by **Marion J. Faber, M.A., R.N.,** was one of the outstanding contributions to the annual meeting of the Nebraska nurses.

About Books

Ask your local library to lend you these books if you cannot own any or all of them

ESSENTIALS OF MEDICINE. By Charles Phillips Emerson, M.D. Eighth revision, assisted by Nellie Gates Brown, R.N. 588 pages. Illustrated. J. B. Lippincott Company, Philadelphia. Price, $3.

THIS new edition of Emerson's "Essentials of Medicine" has been thoroughly revised and reset and includes some 180 more pages than the previous edition. It has been printed on paper of a better quality which makes the book mechanically easier to read.

Several important changes have been made in the organization and content of the book which make it more valuable as a textbook for nurses. There are three new introductory chapters; the division into chapters is more logical; the newer treatments in certain diseases are discussed; and there is a more concrete discussion of the nursing care which patients require.

Of the three introductory chapters, the one on the "general attitude and appearance of the patients" is new; the other two "signs and symptoms" and "temperature, pulse and respiration" were the last chapters in the previous edition. This new arrangement brings this important material to the attention of the nurse as she starts her experience with medical patients.

In this edition there is a better grouping of the material into chapters. For instance, the diseases of the heart and blood vessels have been grouped together rather than the diseases of the blood and the blood vessels. The discussion of "foods and diets" formerly included under the diseases of the gastrointestinal tract has been put in a separate chapter as an introduction to those diseases. The deficiency diseases which before were under constitutional diseases have been given a chapter of their own.

One of the most helpful of the new chapters is on the psychoneuroses. The author has given a very clear and sympathetic exposition of the physical condition of these patients. The nurse will find it of great value in understanding and managing them. Other new material includes the treatment of pernicious anemia by liver diets, oxygen treatment for pneumonia, and the use of the Dick test.

There is great improvement in the presentation of the nursing care necessary in each disease. This has been included under the treatment of the disease. Under the treatment of the diseases of the heart, the nursing measures for securing rest for these patients are emphasized. The nursing treatment for typhoid has been expanded and made very definite. All through the book the treatment has been discussed from the viewpoint of the nurse as well as the doctor.

In using this book as a text, the instructor in medical nursing must select the parts which are a necessary equipment for the nurse. In this way, it may be used in teaching medicine to nurses until we have a text which

presents what the nurse needs to know about medicine, rather than what the doctor must know about medicine.

FLORENCE K. WILSON, R.N.
The Lakeside Hospital, Cleveland, O.

IMPROVISED EQUIPMENT IN THE HOME CARE OF THE SICK. By Lyla M. Olson, R.N. 109 pages. 150 illustrations. W. B. Saunders Company, Philadelphia, 1928. Price, $1.25.

HERE is a little book that has long been needed and which should be welcomed by instructors in nursing procedure whether in nursing schools or in public health nursing organizations. It should also stimulate those who have successfully improvised substitutes for other pieces of equipment to record their successes in the professional magazines.

The complaint is not infrequently heard that nurses do not like to nurse in homes because of the lack of equipment. This book shows that such situations have been a challenge to the imaginative, some of whom have found real adventure through their improvisations.

The experiences of public health nurses, as well as those in hospitals and in private duty, have been liberally drawn upon in the preparation of the book. Each of the 150 illustrations is so clearly drawn that there is no mistaking the points they were intended to bring out. Very little text is required. They cover a wide range of subjects beginning with "Appliances for protecting the mattress" and ending with "Splints." As an example of the type of material Miss Olson has collected, we cite "A method of extracting beef juice" which requires only the family laundry wringer, two pieces of hard wood board, and some waxed paper. Any family would be glad to save the difference in cost between that equipment and a beef press.

The book is commended to all those who teach or practise bedside nursing.

THE SOUL OF THE HOSPITAL. By Rev. Edward F. Garesche, S.J. 207 pages. W. B. Saunders Company, Philadelphia, 1928. Price, $1.50.

THE book is made up of a collection of inspirational articles by this prolific writer which have appeared in various hospital and nursing magazines. Of the soul of the hospital Father Garesche writes:

> The soul of the hospital is the spirit that pervades it, the morale of its workers, their intellectual and spiritual condition and attitude, the motives which impel them, the attitude they take toward their work. This soul of the hospital gives life to all its material functions. The quality of its service, its influence on the patient, its capacity for restoring him to health of body and mind, are dependent on the spirit which pervades its activities, on the attitude of its staff and its other workers, the intellectual and spiritual conditions which prevail within its walls.

Any thoughtful person will agree with his thesis, that no two hospitals are alike any more than any two individuals are alike, and it is essentially the guiding spirit, spacious or contracted, generous or mean, which creates this difference which is so vital to those sheltered under its roof.

RULES FOR RECOVERY FROM PULMONARY TUBERCULOSIS. By Lawrason Brown, M.D. Fifth edition. 233 pages. Lea & Febiger, Philadelphia, 1928. Price, $1.50.

BOTH book and author are well known—the one as a safe guide and the other from extensive experience in the treatment of tuberculosis, well qualified to direct the patient along the recovery road to health.

The new edition is thoroughly revised, and brought up to date with the newer ideas and methods of treatment—rest, exercise, diet, heliotherapy, etc.

Every public health nurse should be familiar with the contents of the book, using it as a basis of instruction for her tuberculous patients. She can safely recommend its use as a daily guide.

ROBERT M. STITH, M.D.
Firlands Sanatorium, Seattle, Wash.

GOITER PREVENTION AND THYROID PROTECTION. By Israel Bram, M.D. 327 pages. Illustrated. F. A. Davis Company, Philadelphia. 1928. Price, $3.50.

THE author states that it is his "intention that this volume be useful and interesting to the non-medical as well as the medical individual." "In the presence of an actual thyroid disturbance both doctor and patient will here find helpful suggestions calculated to create the coöperative spirit so vital to prompt recovery."

After reading the book it is the considered opinion of the reviewer that in the author's attempt to reach both the doctor and the patient his effort is not fully successful. It is a great question whether the literature on goiter that is helpful to a patient with thyroid disturbance is at the same time precise enough and presented in sufficient scientific detail to be of distinct value to the doctor. On the other hand, a book on goiter affections which may provide easy reading for a doctor will necessarily involve an excess of detail for a patient. This is about the only criticism that can be fairly levelled against the book. Its subject matter is, in the main, in consonance with the present-day thyroid teaching. The rules given by Dr. Bram for the protection of the thyroid, his consideration of the giving of iodine in goiter, is timely, sane and thorough. While some of the opinions of the Doctor are not widely accepted by present-day students of goiter he has abstained from a controversial tone and on the whole is entitled to his day in court.

Chapter VIII on "Endemic Goiter in the United States" is a well considered contribution by Dr. Robert Olesen, and one in keeping with the remainder of the book.

There is considerable extraneous matter and it would appear that the book could be compressed into a much smaller volume with added advantages in conciseness and brevity. It is a contribution that may be read with profit and value by nurses and hospital attendants.

Aside from the minor criticisms above indicated "Goiter Prevention and Thyroid Protection" by Dr. Israel Bram may be accepted upon its own merits.

CHARLES GORDON HEYD, M.D.
New York City.

BOOKS RECEIVED

LECTURES TO NURSES. By Margaret S. Riddell. Third edition. 500 pages. Illustrated. Faber and Gwyer, Ltd., London. Price, 4 shillings.

This book, written by a graduate of St. Bartholomew's Hospital, London, is based on British methods and technics. It is said to provide "a concise survey of the whole field of knowledge now required of the fully trained nurse."

ANNUAL REPORT OF THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE OF THE UNITED STATES. For the fiscal year 1928. 345 pages. U. S. Government Printing Office. Washington, D. C. 1928.

Contains a concise and valuable summary of the present status of the nursing service, concluding with: "The morale of the nursing service seems better than it has been at any time since its establishment."

Books You Will Enjoy

ISABEL ELY LORD

YOU will not miss Lytton Strachey's "Elizabeth and Essex," of course. Every one seizes on it, and finds it even a finer piece of work than "Queen Victoria." No easy task, this, to make a coherent tale out of the tangle of the devotion of the Virgin Queen to her Lord Essex, the last of the knights of chivalry, and his devotion to her. But out of the tangle that leads to so tragic an end for him—an equal tragedy for her—Mr. Strachey has woven a tapestry of much beauty, and one without flaw. He has made us understand that great queen, and that figure of romance and inconsistencies, her lover. And in the telling he has painted an incomparable picture of the Age of Elizabeth (Harcourt, $3.75).

A poem that fills a whole volume may seem formidable to many, but no one who starts Stephen Vincent Benét's *John Brown's Body* (Doubleday, $2.50) is likely to fail to finish it. The story of the Civil War is told in sketches and interpretations chosen here and there in North and South alike. Some critics have complained that there are stretches of the poem that are almost commonplace, but if all the verse were as poignant and moving as are many passages, no human being could keep himself continuously at such heights. The narrative parts are a necessary relief to the lyric and tragic high lights of this poem—American to the core, and having the "inevitableness" of great poetry.

All who are interested in the problem of adolescence will wish to read Margaret Mead's *Coming of Age in Samoa* (Morrow, $3). The study was made for the purpose of helping with our own problem of the boys and girls who are "coming of age," and the results are full of suggestion for our education at home and in school. Miss Mead has written a book that is not only of great value, but of absorbing interest.

Stuart Sherman's early death was a serious loss to American letters and American culture. In *Shaping Men and Women* Doubleday has collected Mr. Sherman's talks and articles about education, especially that of the colleges and universities. They are full of meat, and in addition most readable ($2).

One of the most delightful novels of recent days is Maristan Chapman's *The Happy Mountain* (Viking Press, $2.50). Not only in the speech of the Kentucky mountaineers, but also in the narrative, she has used the quaint words and phrases of the mountain folk—often those of Shakespeare. There is fighting and wrath in the book, but it ends happily, and throughout it breathes and blows the free air of the blue mountains.

J. G. Snaith's *Surrender* (Appleton, $2) is something like *Beau Geste*, in that it is a tale of the Foreign Legion, but there is much more love-interest in it. It will while away a pleasant hour or two for those who like their love and adventure mixed.

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